children

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A professional journal on services for children and on child life (*formerly* THE CHILD)

For 20 years Dr. J. Roswell Gallagher has devoted attention to adolescents. He served successively as physician at the Hill School, Pottstown, Pa.; Phillips Academy, Andover, Mass.; and Wesleyan University, Middletown, Conn.; before joining the staff of the Children's Hospital in Boston and organizing the Unit he describes in these pages. Through research sponsored by the Carnegie Corporation and the Grant Foundation, Inc., he has contributed extensively to knowledge about the physiological, growth, medical, and emotional problems of adolescence.

A psychiatrist whose major concern is to find ways of applying knowledge about mental health to public-health work, Dr. Gerald Caplan has conducted experiments in this direction not only at the Harvard prenatal clinic he writes about here but also at a well-baby clinic in Israel, where for 4 years he was adviser in psychiatry to the Israeli Minister of Health. In his native England, he engaged in research in shock treatment and in psychiatric work with children at the Tavistock Clinic in London.

Before becoming director of the Special Juvenile Delinquency Project, Bertram M. Beck was for 4 years with the Community Service Society in New York, most recently as assistant director of its Bureau of Public Affairs. A graduate of the School of Social Service Administration, University of Chicago, he has had experience in family casework, child guidance, institutional administration and parole supervision. During World War II he served as psychiatric caseworker with the United States Air Force.

Problems of hazardous employment among children and youth have long concerned Clara M. Beyer, who writes in this issue of pinboys in bowling alleys. Before joining the staff of the Bureau of Labor Standards in 1934, she headed the Industrial Division of the Children's Bureau, then also in that Department. Previously she was executive of the Minimum Wage Board of the District of Columbia. A native Californian, she has taught at University of California and Bryn Mawr College.

The only woman with director's status presently in the United Nations Secretariat, Julia Henderson has been with the UN staff since the days of the Preparatory Commission. Originally on loan through the U. S. State Department she became chief of the policy division of the UN Bureau of Finance before going to her present position in 1950. With a Ph. D. from the University of Minnesota, she was the first woman ever admitted to Harvard University's Graduate School of Public Administration.

Frontispiece

"TODAY, education is perhaps the most important function of State and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where the State has undertaken to provide it, is a right which must be made available to all on equal terms.

We come then to the question presented: Does segregation of children in public schools solely on the basis of race, even though the physical facilities and other 'tangible' factors may be equal, deprive the children of the minority group of equal educational opportunities? We believe that it does . . .

". . . To separate them from others of similar age and qualifications solely because of their race generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone . . .

"We conclude that in the field of public education the doctrine of 'separate but equal' has no place. Separate educational facilities are inherently unequal . . ."

Brown v. *Board of Education, Supreme Court of the United States. May 17, 1954.*

—Photo by Esther Bubley

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READERS' EXCHANGE

BECHTOL: Encouraging to Physicians

As Dr. Charles O. Bechtol points out, it is encouraging to physicians faced with the problem of prescribing prosthetic appliances for young children to know that the Advisory Committee on Artificial Arms of the National Research Council is to apply its knowledge to the problems of the child amputee. (See "Artificial Limbs for Child Amputees," CHILDREN, Vol. 1, No. 3).

The decision of the committee to use this knowledge for training physicians and therapists, rather than simply to release the device to the public, is highly important.

As Dr. Bechtol states, the greatest needs at the present time are for parental guidance, for more knowledge about the proper age at which to fit a child with an artificial arm, and for the type of arm best suited to do the tasks the child is interested in performing at various age levels. In our children's division, we have found that around 4 years of age seems to be the best time to supply the child with an artificial arm, because it is the age when he is most interested in bimanual activities such as stringing beads, scribbling on paper, and cutting with scissors.

Is the utility hook or the functional hand better for a child? Personally I will have to see more evidence on the advantage of hooks than is now available before I will prescribe one for a pretty little girl. At Children's Service we have found that usually the functional hand meets the needs of our child amputees and it seems to be more acceptable to parents. As the child develops and wishes to perform activities which are not possible with the hand, we supply a hook which can be used when desired.

Generally, the differences of opinion among physicians who designate the type of arm the child is to have are based not on reliable evidence, but rather upon the ideas of old limb makers and the desires of parents.

My hope is that this important research and work program will be continued until we know how and when to prescribe the best devices to fit the needs of the child and to help him to make the best psychological and social adjustment to his handicap.

G. G. Deaver, M. D.
Medical Director of Children's Service, New York University, Bellevue Institute of Physical Medicine and Rehabilitation.

WASKOWITZ: Dynamic Help

The story of "Foster Family Care for Emotionally Disturbed Children" as told by Verna Waskowitz of the Family and Children's Society of Baltimore, ("Foster Family Care for Emotionally Disturbed Children," CHILDREN, Vol. 1, No. 4) marks a milestone in the history of the development of foster care and has important implications for the child-placement field as a whole.

This article reveals the agency's conviction that the child's own family and own parents are vital to his growth and development. At the same time, it leaves the reader with the conviction that placement is not necessarily a discouraging "last resort."

Psychologically this concept is most vital in implementing the placement worker's ability to help the child. Only when placement is regarded as a helpful process to the child and his own family, to the point where they can unite and accept each other with greater tolerance and understanding, or can live apart more comfortably, does the social worker feel free to utilize fully the potentials of placement.

From the Jewish Child Care Association's special project for exceedingly traumatized children (several of whom have been diagnosed as psychotic), begun in 1950, we too learned that psychiatric help given to the child, along with intensive casework to him, his family, and his foster family, produce results which are encouraging.

Evelyn Spiegel
Director, Foster Home Department, Jewish Child Care Association, New York

Foster Parents Needed

The program of the Baltimore Family and Children's Service for emotionally disturbed children as described by Verna Waskowitz is an encouraging challenge to child-placement agencies.

The task of helping disturbed children who must live apart from their own families is an old and formidable problem, but as new insights are gained, new endeavors get under way. The recent developments in the establishment of treatment centers represent one type of effort; the specialized foster home is another. Others will come, as will refinements and clarification of methods.

An essential aspect of the program described by Miss Waskowitz is the greater responsibility assumed by the agency, through the caseworker, toward the foster parents. The worker not only is on hand when crises occur, but—what is essential—she anticipates and averts crises and emergencies.

One of the aims of the program is to strengthen the day-by-day living experiences for the child in order that he may master new habits of feeling and acting. Just as houseparents in a treatment institution require a continuous educational program, so do foster parents if the goals are to be achieved.

This program, as well as general programs of child placement, is up against the fact that the lack of adequate foster homes is often the greatest obstacle in providing good care for children. As a result of this lack, many children become emotionally disturbed under agency auspices.

Traditional methods of recruiting foster parents are not sufficiently effective. The search for *specialized* homes requires new assumptions and new methods which will contribute not only to the welfare of the special child, but also to the welfare of the other children cared for by a child-placing agency.

Lois Wildy
Illinois Children's Home and Aid Society, Chicago

WITMER: Community Climate and Delinquency Control

An outstanding quality in the discussion of parental responsibility for juvenile delinquency reported by Helen Witmer ("Parents and Delinquency," CHILDREN, Vol. 1, No. 4), was the humility with which these well-qualified persons approached their task. None of the discussants maintained that his special approach is the final or basic solution to the complex problem of delinquency.

As Mr. Lourie and Dr. Bloch both indicate, our lack of specific knowledge and techniques prevents us from pinpointing our treatment efforts more effectively. However, a highly important factor in delinquency control is the

community climate—whether it is understanding or hostile, whether it recognizes the problems of the so-called marginal families, or rigidly imposes middle-class standards that they cannot attain. Authority, both of law and of community standards, is of key importance in reaching such families, but it can be highly destructive, too, if it arises out of workers' frustration or bureaucratic impatience with the vagaries of human behavior or the apparent "orneriness" of individuals with deep-seated problems. Much depends on *motivation* for the use of authority.

While agreeing with Dr. Shaw's contention that clinics have geared their approaches to middle-class problems, I cannot go along with the implication that this a static situation. Under the impact of integrated, community-wide programs such as the one we operate in New York City there are clinics and social agencies which have either moved, or showed potentalities for movement, away from such a position. It is important for progress that this be recognized. Likewise while I cannot quarrel with Dr. Shaw's analysis of the community's role in either fostering or preventing delinquency, this viewpoint must not be overstressed to the point of neglecting improvement of individual treatment services, as can well happen in the enthusiasm that the area-project approach engenders and even demands. Like other proposed solutions, the area-project approach is not the total answer.

Ralph W. Whelan
Executive Director, New York City Youth Board

YUM: Extended diagnostic service

The description of the nursery-school activities at Michael Reese Hospital is excellent ("A Nursery School for Cerebral-Palsied Children," by Louise Yum, CHILDREN, Vol. 1, No. 4). It includes many ideas and activities which can be carried out in other nursery schools, and which are basic to the socialization and development of school readiness of cerebral-palsied children.

As I read the article, however, I hoped that there might be some indication that the observations made by the staff might be relayed to the teachers receiving them in more advanced classes. Ideally, teachers should be given opportunities to observe children in their nursery-school activities and to discuss the evaluations of their progress with those who have dealt with the children in the nursery-school class.

Again I feel that we might well place more emphasis on the function of the nursery school as an extended diagnostic service. This was implied in the article, but I hope that in other reports on similar projects this aspect of the program can be pointed out more definitely. The success of educational programs for the cerebral palsied must depend to a great extent on evaluation of children's needs and abilities as they may be obtained in the nursery-school class. This can be achieved through observation, diagnostic teaching, and the frequent meeting of medical, therapeutic, psychological, and educational personnel to discuss the progress of the children: I am sure that this is what goes on at Michael Reese.

My congratulations to the author and to the Children's Bureau for making this type of material available.

Arthur S. Hill
Educational Director, United Cerebral Palsy, New York

HOCHFELD: Long-Distance Casework

The American caseworker, faced with the variety and complexity of unknown forces operating in what Eugenie Hochfeld calls "long-distance casework," ("Problems of Intercountry Adoption," CHILDREN, Vol. 1, No. 4), needs great inner security to accept her limited role. The worker has to recognize that her part is a small one, but if she carries it with full responsibility it may be very significant.

If we recognize the purpose of the law, as intended for the real benefit of many children, and if in spite of its deficiencies we make the best use of it, we may be sure that it will accomplish great good.

We know mistakes will be made. There will be some heartaches when we are dealing with human beings. This happens even under the best and most controlled circumstances.

The evidence already available indicates a higher percentage of success than could have been predicted. But the anxiety of private agencies could be greatly reduced if there could be provision for public support of children for whom they are unsuccessful in planning.

Through cooperation with International Social Service, American social workers can learn a great deal that can be applied to our practice in the United States. Our experience in intercountry placement may help some of us to be less fearful of life.

Eleanor W. Gordon
Formerly Director, Child Placing and Adoption Committee, New York State Charities Aid Association

CLOSE: Confirmation of Travelers Aid Experience

It is heartening to read in the story of the Conference on East Coast Migrants ("Combining Forces for Migrant Children," by Kathryn Close, CHILDREN, Vol. 1, No. 4) of the steps taken to better the conditions of migrant agricultural workers. Travelers Aid Societies, while not located adjacent to the farms on which this "stream" lives and works, see the effects of the difficulties and conditions encountered by families as they move about seeking work or striving to return home. Often traveling independently of crews they come to centers of populations where Travelers Aid Societies are located. These families present many problems, but especially noticeable are the results of child labor, insufficient educational and recreational opportunities for children, bad housing and sanitation, inadequate incomes, and inadequate child care.

In contrast to many people seen by Travelers Aid Societies, migrants move within a reality based pattern for practical reasons rather than out of "flight" from emotional problems, and service to them must be based on recognition of this fact. However, discrimination against the nonresident whose presence in a State has frequently been encouraged by governmental agencies often blocks constructive help by closing local resources to them.

As the report of the conference points out, the problems of migrants touch many facets of social organization, and their solution will not be found in any one answer. Legislation providing necessary financial assistance and medical care, acceptance by communities, including schools and employers, availability of social agency's services, voluntary as well as tax-supported, are all important. The initiation of the project on East Coast migrants to unite the interests of many forces, both governmental and voluntary, seems at last to provide a constructive approach.

Margaret Creech,
Director, Department of Information and Studies, National Travelers Aid Association

All the problems of growing up come into the focus of staff physicians at . . .

A CLINIC FOR ADOLESCENTS

J. ROSWELL GALLAGHER, M. D.

Chief, The Adolescent Unit, The Children's Medical Center, Boston

ADOLESCENTS being neither little children nor adults, their needs, their interests, their attitudes, and even some of their physical ailments differ both from those of younger and from those of more mature people. Why then, would their medical needs not best be cared for in a setting devoted exclusively to them?

Believing that an affirmative answer to that question is the correct one—believing that *adolescents are different*—Boston's Children's Hospital has established an outpatient and hospital service designed exclusively for the care of boys and girls from 12 to 21 years of age. This Unit is devoted entirely to the treatment and study of young people and to the training of physicians in the care of adolescents.

For many years we have had hospital services devoted to little children and others for adults. Adolescents fit awkwardly in either of those services, no more at ease next to a sniffling 8-year-old or to a crib than to adults recuperating from a hysterectomy or prostatectomy. Not only are adolescents uncomfortable when grouped with such companions, but so too will be their physician unless he can readily change his manner, and his mode of treatment.

Adolescents will be more comfortable in a place of their own, and their physician will be more effective if he has readjusted his thinking to fit their needs. Not what upsets a child or an adult, but what is most likely to upset an adolescent, must be on his mind. Not how to manage obesity or menorrhagia or hypertension or backache in a 50-year-old, but in a 15-year-old, must govern his judgment if he is to serve his patient best. Being different, adolescents require different management.

Heretofore adolescents have not been the special concern of either the pediatrician or the internist. They have not been neglected, but they have not had the special attention which we have given to other age groups. Yet it is fitting that they should. These young people are at a crucial point in their lives, a time when the kind of care they receive can make a tremendous difference. Good care they have to have, but the best of care they can only hope to get by our developing services exclusively for them—facilities where their requirements and ways of fulfilling them can be studied and where a physician can acquire additional knowledge about them.

The Adolescent Unit established at the Children's Hospital in Boston in 1952 provides adolescents with a complete program of medical care. In this Unit, all manner of illnesses and problems which beset these young people are treated. It is not a specialty clinic. On the contrary it is a general-practice clinic, devoted to an age group rather than to a certain type of illness or to a single kind of problem.

All people between the ages of 12 and 21, regardless of their complaint, are offered help at the Unit. Boys or girls with stomach trouble or headaches or painful backs, those who are failing in school, whose eyes or ears are troublesome, or who cannot get along with people at home or at school, all come within the interest and province of the Unit's physicians.

Specialists' help is available for those adolescents who need it, but within the Unit, the specialist is primarily a supervisor, a consultant, a teacher. He may talk to and examine the girl who has menorrhagia, but after a discussion of this problem with

—*Photos by Esther Bubley*

her physician, he will in almost every instance leave her future care and management to him. Whenever a patient requires special techniques or the advantage of the special skill which a specialist possesses, the patient is referred to that specialist and to his service for study, treatment, or even for long-continued care. However, whenever the adolescent can be satisfactorily cared for by the physician who is trained in the care of members of this age group, the patient remains with him. In this way a close personal relationship is developed and maintained between the physician and the adolescent, with the emphasis kept on the person and not the ailment. However, when the patient requires surgical or ophthalmological, psychiatric, or orthopedic care, or other treatment best obtained under a specialist's management or in a special clinic, a transfer is made.

The Unit attempts to fulfill four main objectives. Its primary purpose is to offer young people their own outpatient clinic and hospital facilities and their own physician just as for many years little children and adults have had theirs. Secondly, it was developed so that physicians might have an opportunity to become trained in handling adolescents and so become familiar with the medical and emotional problems which commonly affect these young people. The third objective is to provide research workers with a single setting as a focus for their studies in the health problems of this age group—a place where the representatives of a variety of disciplines might bring their various skills to bear on adolescents' problems. And lastly, the Adolescent Unit was established so that physicians might have an opportunity for training in the *care of a person* in contrast to training in the *management of a problem*.

Special Concerns

Although the Unit is interested in the great variety of illnesses, injuries, and emotional and behavior difficulties exhibited by young people, its staff attempts to keep in mind four special concerns significant to all adolescents, no matter why they come for help.

The first of these is the adolescent's concern with his or her own growth and development. Size makes little difference to a child or to an adult, but to be too short or too tall, too fat or too thin, or to mature less rapidly than one's companions are matters of considerable importance to an adolescent. Young people want to be average and they want to be sure they are normal. But they have little understanding of either of these terms, and little or no understanding of the wide variation in the rate, extent, and time

Respecting a young person's normal desire to understand his problems is a primary policy of the Adolescent Unit at the Children's Hospital in Boston. Here one of the Unit's physicians interprets an X-ray film of a knee injury to a patient.

at which perfectly normal young people grow. Frequently when they deviate from what they believe is the normal, they become anxious and develop symptoms which simulate illness.

A second concern grows out of the adolescents' habit of strenuous living. They don't just play around any more as little children do, and they don't sit in a chair all day as do many adults. They go at things hard, they go at things to win, and their questions to physicians in regard to the fitness of their backs or knees or hearts need to be answered with due attention to the fact that they live strenuously. They do not ask whether their hearts are fit for office work or playpen; they ask if their hearts are fit for a mile run or soccer. In connection with this, the physician needs to remember the effect which restriction of their normal activities can have upon them.

Thirdly, the Unit's staff keeps in mind both the adolescent's concern with school and the school's effect on the adolescent. Though young people are often not very fond of school, it nevertheless affects their lives and sometimes their health. Most adolescents want to succeed, and when their schoolwork goes poorly, this fact may account for their upset stomachs or their headaches. Not to have school in mind, not to question them about it, not to determine their attitude toward it, is to leave out a very important potential cause of many symptoms usually associated with illness.

And finally, the Unit keeps in mind a number of other concerns which commonly cause adolescents

anxiety: confusion about death or religion; the acquisition of independence; sex; conflict in the home; acceptance by their contemporaries; and the assumption of adult responsibilities.

In addition to the special concerns characteristic of adolescence, young people suffer illnesses and injuries peculiar to or very common in adolescence. Observation of these is important in the training of practicing physicians and in research directed toward a better understanding of adolescents. We need more knowledge of these illnesses and of adolescents' reactions to them, in order to solve problems in endocrinology, in the prevention and care of athletic injuries, in the management of adolescents who are handicapped by diabetes, epilleptic seizures, acne, in a variety of emotional difficulties, and in such conditions as epiphysitis of the spine and in dysmenorrhea and menorrhagia, to mention only a few.

Program

The Unit was opened in the fall of 1952. Since that time it has grown rapidly so that it now handles more than 500 patient visits a month. The young people are referred to the Unit by family physicians, specialists, social agencies, public and independent schools, colleges, and guidance centers. They come not only from Boston and other parts of Massachusetts, but from many other sections of the United States and even from foreign countries. The Unit's staff and its quarters are being expanded as rapidly as possible to take care of an increasing demand.

Desks are taboo in physicians offices at the Adolescent Unit as bars to an informal atmosphere. The kind of easy relationship, achieved by the physician and patient pictured below is fostered to help the physician see the person behind the problem.

In addition to providing facilities for the diagnosis and care of medical and emotional disorders, injuries, and surgical conditions, the Adolescent Unit has already inaugurated some programs which reach outside the hospital walls. It has interested itself in the health services of nearby social agencies and of such institutions as the Boys' Club of Boston. It has also developed a small division which devotes its attention to training teachers in methods designed to help young people badly handicapped in school because of a specific language disability and who, despite high intelligence, spell atrociously, read inefficiently, and even write and talk poorly. The division has been developed to meet a need which became increasingly obvious as more and more adolescents who came to the clinic for a variety of other reasons were found to be handicapped by this condition. It is hoped that its activity will prove not only to be of considerable help to many promising adolescents but also bring about a closer liaison between the educational and medical professions.

The Unit also offers training to physicians who intend to devote their time to the care of students attending public or independent schools or colleges. Few other opportunities exist for such orientation. The Unit's general practice setting, its staff's interest and experience in schools' medical problems, its school-age patients, and its cooperation with nearby schools and the Harvard University School of Public Health all combine to make possible the offering of a well-rounded training program to physicians who would be school doctors.

The Adolescent Unit is not a specialty clinic. Neither do those who are planning its program have in mind the training of physicians who will subsequently be considered as specialists in the field of adolescence. On the contrary, the Unit offers training to general practitioners, internists, and pediatricians, not that they may become specialists, but that they may have an opportunity to learn more about adolescents and increase their skill in the management of those adolescents who will come to them in their later practice. Within the Unit itself, however, the teaching staff confines its attention to adolescents, though most of the consultants who participate in the training program care for patients from a variety of age groups in the course of their own practice.

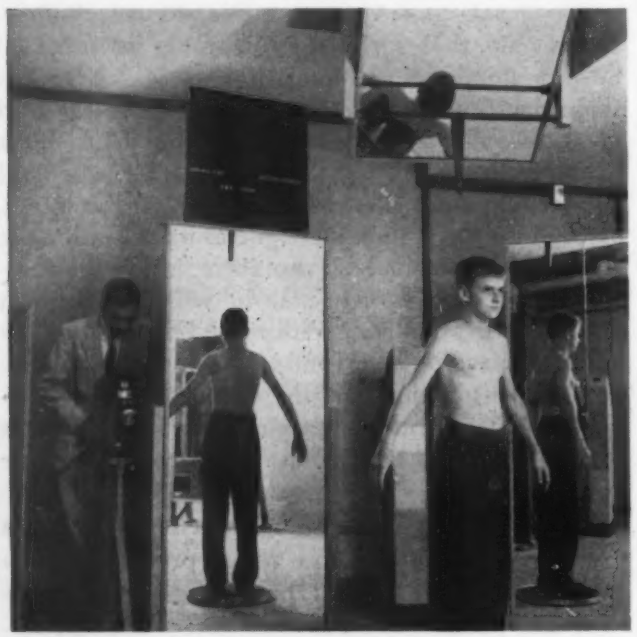
The Unit's physicians who comprise its full-time teaching staff include those whose previous experience has been in general practice, internal medicine, and pediatrics. The consultants and special-

ists who train these men as well as physicians at the Unit for a temporary period of training, are experts in endocrinology, gynecology, cardiology, dermatology, psychiatry, ophthalmology, orthopedics, neurology and other branches of medicine. As the Unit's staff and facilities expand, experience with, and training in the management of health problems in adolescents will be extended to those of the hospital's house officers who wish it, to medical students, and to practicing physicians who apply.

The Unit's research program is in no more than the planning stage. Preliminary studies of the incidence, causes, and management of dysmenorrhea have begun. The problem is being approached from the clinical, the laboratory, and psychological points of view. The Unit is also accumulating data which will be helpful in outlining an extensive study of the interrelationship and relative value of serum cholesterol, protein-bound iodine, and the basal metabolic rate in the diagnosis and management of hypothyroidism in young people. The Unit is also planning a long-term study of adolescents with a considerable degree of systolic hypertension.

Another major research project under discussion is a long-term study of the causes, the early recognition, and methods of remedying specific language disability. The investigation of this subject contemplates a multidiscipline approach utilizing knowledge of genetics, neurology, education, psychology, hematology, and electroencephalography.

Though it's done with mirrors there's no trick at the Adolescent Unit in the careful recording of changes in body structure. This procedure was adopted in recognition of rate-of-growth not only as symptomatic of health or ill-health but also as of great importance to the young person's feeling about himself.



The Unit has already installed equipment to test the value of a new photographic technique in such fields as growth and development, orthopedics, and constitutional medicine. This is in line with our general intention to confine our research activities to inquiries which have clinical applicability to the patients who come to the Unit and which are best investigated in a setting offering large numbers of adolescents for study. In many instances our research will be carried out in collaboration with other departments of the Children's Medical Center, the Harvard Medical School, and Harvard University, and, occasionally, other institutions.

Sam

There may be no better way to make clear both the need for these young people to have a clinic of their own and for physicians to have the opportunity of receiving training in their ailments and their characteristics than to tell the stories of a few of the Unit's patients.

Sam first came to our clinic when he was 15. He was brought in by his very excited and nervous mother because she had been told that he had signs of heart disease. The physician to whom Sam had previously been referred, though reluctant to make a definite diagnosis of heart disease, had suggested the importance of reevaluations of his heart at regular intervals and had urged a strict curtailment of his activities.

A brief talk with Sam's mother at her first visit to the Adolescent Unit yielded nothing in the way of history to suggest heart disease in the boy or other members of his family, but it did give the Unit's physician the opportunity to appreciate her great anxiety and to become aware of the constant supervision which she was now exercising over her son. She explained that he had been thoroughly examined, that he had been fluoroscoped and that electrocardiograms had been taken and that complete laboratory studies had been made. Three or four repeated examinations had, according to their doctor, revealed no change in his general condition, and she now wanted to be assured that nothing more could be done.

Sam's general appearance was that of a normal, healthy boy. Nevertheless his anxiety was obvious as was his relief when he discovered that his mother was not going to participate in his visit with the doctor nor be present at his physical examination.

Taking an aptitude test, this girl is helping the doctors learn something of her native abilities—important to their understanding of whether frustrations in school or at home may be causing the symptoms that brought her to the clinic.

After he had been asked the usual questions about his previous health and about the presence or absence of a variety of symptoms, and had told of his interests, his summer activities, and his future plans, he was considerably more at ease. When asked whether he liked school or not, he talked freely and was able, without hesitation, to describe his feelings about his young, attractive teacher. Finding his doctor listening without being shocked or critical, he went on to explain how his heart would sometimes pound and how he would have very guilty feelings because of his thoughts and actions. Allowed to talk, it was not long before he burst out with: "I was terribly scared when I went to those doctors. I was afraid they would find out. It *is* bad to masturbate, isn't it?"

Sam's physical examination showed nothing of any importance. Even his heart rate, which had been considerably accelerated at his other recent examinations, and which was the primary reason for physicians suspecting that he might have some heart disease, was well within normal limits. What Sam really had was anxiety. He was confused and guilty about those feelings and thoughts of his and about his masturbation, and being in an anxious state, was beginning to wonder if perhaps he did have heart disease. After all, the doctors thought he might, and his heart did pound a great deal.

Variation from the normal character of heart sounds or of the heart rate or rhythm must not be overlooked, but it is important for physicians to remember that factors other than heart disease may be involved and that the worries which cause adolescents confusion and anxiety can also produce pain over the heart or a rapid beat. Given an adequate opportunity to talk alone with his doctor and away from his parents, the worried adolescent is usually quick to come out with the source of his anxiety.

"What kind of a person am I dealing with," is as much if not more important to the physician than the question: "What sort of heart disease could I be dealing with?"

Mary

On the other hand, it can be just as disastrous for the physician to jump quickly to the conclusion that an adolescent's symptoms are entirely "psychological." Up to her sixteenth year, Mary had got along beautifully both at home and at school. Then she gradually became more irritable, made nasty remarks with little provocation, easily broke into tears, and, according to her teachers, no longer seemed able to concentrate. Some of her teachers thought the trouble was "boys." Her mother, upset by a variety of other problems, had several explanations, but her favorite was that Mary was beginning to show a nasty streak and was becoming more and more like her father. A psychologist suggested that Mary was expressing long suppressed feelings of hostility against her mother and that she was also having difficulty reconciling herself to the process of becoming more feminine.

There was undoubtedly some truth in these observations. The mother was a very strong, efficient, and dominant person whose well-meaning interference it would be easy to resent; and a few minutes conversation with Mary brought out the facts that she was not interested in boys, but loved to play softball and field hockey, and to help her father work on the car—all of which though healthy enough in themselves, hardly indicated an avid desire to become more feminine.

Mary's father was the practical, hard-headed type. He stayed out of the discussion about her at first, but when she not only failed to improve, but actually became more and more nervous, he finally said he had "had enough of all this nonsense" and was going to take her to a doctor for a complete physical examination.

It is as easy to overlook the obvious when you see

a person daily at home or at school or at work as it is easy to detect the unusual in a person you have never seen before. Mary did not look like the sort of girl who would want to be nasty, but she certainly seemed to be excessively nervous. She stared, she could not sit still, her nails were bitten down to the quick. It was not surprising that her laboratory findings bore out the diagnosis which her very rapid heart rate, her excessive sweating, bulging eyes, and moderately large thyroid gland strongly suggested. Undoubtedly this girl was annoyed at her mother's bossiness and was not yet desirous of trading her basketball shoes for silver slippers, but her primary difficulty was hyperactivity of her thyroid gland.

A thorough inquiry into an adolescent's physical status, and due attention to the illnesses and physiological changes which are common in those years is just as important as attention to the psychological factors which can produce misleading symptoms.

Susan

Techniques of examination and treatment which are appropriate for an adult may be far from ideal for an adolescent with the same ailment. Similarly, the cause of the anxiety which accompanies the disease may not be the same in the adolescent as it is in the adult. Susan, who came to us with menorrhagia, clearly illustrates these points and the desirability of having a special setting for adolescent care. Her story shows the importance of offering physicians training to help them understand adolescents and the differences in the same illness when it is seen in the adolescent and when it is seen in the adult.

Since the beginning of Susan's menstrual periods 2 years previously there had been considerable irregularity, both in the interval between them and in their duration. On two occasions, the flow had continued for as long as 4 weeks. At the time we first saw her, her mother had become very worried because the flow had persisted for 28 days, and although on many of those days the flow had been scanty, it had become quite profuse during the previous 2 or 3 days. Susan's previous physician after he had thoroughly examined her—including a pelvic examination—had said that if this difficulty recurred, she should have a dilation and curettage.

Susan, an alert, attractive young girl, did not apper ill. She showed much less evidence of anxiety than did her mother. It quickly became apparent to the clinic physician in talking to her that such anxiety as she had arose from worrying that her symptom might keep her out of normal activities, and prevent her from returning to her summer camp. At her age, and at her stage of emotional development, this vacation—being away from home, with girls of her own age, swimming, horseback riding, mountain climbing—mattered much more to her than the persistent flow. The fact that she had menorrhagia did not bother her, but she *was* worried about the possibility that it might spoil her summer. An adult with this symptom would certainly be worried about the menorrhagia itself and its possible cause.

A thorough medical history, including a charting of Susan's menstrual periods, a physical examination—omitting a pelvic examination—a blood count including examination of the platelets and clotting time, and a tourniquet test were all that were necessary to form an opinion of the nature of her difficulty and make it possible to reassure her mother.

Once the Unit's physician could be sure that no blood dyscrasia was present, he could properly explain this disorder on the basis of the wide variations of menstrual pattern which occur in early adolescence. It was possible too, with his knowledge of variations in the physiology of this process in adolescence, for him to remove Susan's worry about her summer camp and to assure her that her difficulty could be controlled and that it need not interfere with her activity or bother her in any other way. To do this, and to spare her the discomfort and emotional reaction she might have had from pelvic examination or instrumentation, were tremendously important from the standpoint of her future attitude toward sex and femininity. For her to associate normal biological processes with discomfort, disappointment, and distaste, would be most unfortunate. It was clearly of importance here for the physician to keep in mind the sort of things which upset and worry an adolescent, as well as the physiology associated with her symptom and the methods of examination and treatment appropriate for a young girl.

The physician treating adolescents must be aware of their physiology, of the illnesses they are likely to develop, of their interests, and of the things that confuse and upset them. These are not identical with the ailments, the physiology, the worries, or the emotional reactions of either little children or adults.

Though the Adolescent Unit cares for, studies, and gives training in the treatment of young people who have acne, athletic injuries, obesity, poor nutrition, headaches, or indigestion, failure in school, rebellion, hernia, heart disease, poor reading skill, or asocial behavior, the focus remains on the person, not the problem.

A prenatal clinic tries mental health concepts and the teamwork approach in . . .

PREPARATION FOR HEALTHY PARENTHOOD

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FOR THE PAST 3 YEARS the Department of Maternal and Child Health of the Harvard School of Public Health has been exploring the possibilities of a team approach to the provision of health services to families, beginning early in the wife's first pregnancy. The team consists of specialists in obstetrics, pediatrics, nutrition, psychiatry, social work, and public-health nursing. It attempts to uncover in initial stages any physical or emotional factors which might disturb family health and stability, and to remedy them before they have done serious harm.

While it is too soon to present conclusive results from these family studies, an account of the clinical experiences of the team in dealing with some typical emotional problems which have emerged will illustrate a kind of mental-hygiene service for young people approaching parenthood made appropriate by present-day knowledge.

The team first meets the families in a prenatal clinic, and later, after the birth has taken place, maintains contact with them in a well-baby clinic. During pregnancy, the expectant mother, often accompanied by her husband, makes 10 to 12 regular visits of about 2 hours' duration to the clinic. She sees the obstetrician and the public health nurse on each occasion, and in addition one or more of the other specialists. Each of these last routinely schedules two or more interviews with her during the course of her pregnancy and increases the number if he feels that extra service is indicated or if the patient requests it. The public health nurse routes the patient to the different interviewers and helps her learn the professional roles of the various workers, usually a rapid process. The services of the specialists are coordinated at pre- and post-clinic conferences where each patient is discussed and her treatment plan laid out. Experience has shown that this system leads to the development of an affectional tie between each family and the clinic as an institution, as well as to individual relationships of varying intensity with each of the specialists.

Significantly, in this project the mental-hygiene work has not been regarded as solely the province of the psychiatrist, but involves each team member. At first, for about a year and a half, the psychiatrist saw the expectant mothers and their husbands routinely—mainly in order to collect research data. Except in a few instances of special complexity, he did not himself intervene psychotherapeutically, but used his findings to help the other specialists plan the management of their cases. After his data had been collected, he began operating solely as a consultant to the other team members, having no direct contact with the patients. All the workers have become alert to the implications of their specialized work as regards the emotional life of their patients and consult regularly with the psychiatrist in order to work out the mental-hygiene techniques appropriate to their specific functions and each expectant mother's individual emotional needs.

The team as a whole also operates in many instances as a mental-health unit with a defined aim. This is achieved by building up an appropriate

emotional atmosphere through conscious attitudes towards each patient arrived at during the post-clinic conferences. The general role of the team unit is similar to that of a good mother. The patient is made to feel that her individuality is respected and accepted. At certain stages of pregnancy some expectant mothers are allowed to become very dependent on the clinic team as a whole or on specific members, but at all times emphasis is unobtrusively placed on the patient's adult status. She is encouraged to ask questions and to express doubts and differences of opinion. Suggestions and criticism on the running of the clinic are solicited. All members of the team have learned to listen patiently.

The rationale behind this supportive approach is that in addition to helping to bolster the psychological strength of the patient, it involves the expectant mother, as recipient, in an experience similar to a healthy mother-child relationship. The hope is that she may relate to her child in the same way that the team unit does to her. In cases where the patient has never experienced such attention from her own mother, this therapeutic approach is intensified and is continued during the first few months of the child's life.

The behavior of the team members usually leads to the rapid growth of a confiding, trusting attitude on the part of the patients. Occasionally this turns into extreme dependence during the later stages of pregnancy and in the lying-in period. After the young mother has learned to care for her baby with some confidence her attitude to the clinic team becomes one of friendly cooperation on an adult level.

The patient's positive feeling facilitates the collection of important information about her emotional life. It is also valuable in motivating her to accept advice on health habits. Nevertheless, some instances of difficulty in cooperation have arisen, particularly in relation to changing food habits.

Difficulties

The importance of adequate nutrition during pregnancy for the production of a healthy baby leads the clinic to place strong emphasis on correct diet. The dietary advice given by the obstetrician or the nutritionist usually comes at a time when the metabolic processes of pregnancy produce an increased desire for food, and therefore often meets with some, and occasionally with great, resistance on the part of the patient. This often comes from a patient with a history of childhood feeding battles provoked by a difficult relationship with her mother. Sometimes such patients can be helped by being shown how they are incongruously transferring the old pattern of fighting against mother onto the nutritionist and obstetrician. Sometimes it takes other members of the team with whom they may have a more positive relationship to get them to see the importance of a correct diet—an example of the use to which the patients' various types of relationships to the team members can be put. So far no patient has consistently ignored every member of the team.

Another type of patient who has especial difficulty in following the advice of the nutritionist is the expectant mother with predominantly negative attitudes towards her pregnancy. Experience shows that understanding, patience, and sympathetic support help many of these women to free themselves sufficiently from the burden of their mixed feelings to allow them to control their eating habits. The more they can be helped to express their negative feelings verbally, the less do they need to act them out.

It is extremely difficult for non-psychiatrically trained workers to understand and control their own natural feelings of frustration in respect to the uncooperative patient, particularly in the case of the immature, self-centered girl who appears to be rejecting her pregnancy for purely selfish reasons. One of the strengths of the clinic has been the team spirit, which has supported the individual workers so that they have been able to express these feelings in case conferences. They obtain the help of the group in overcoming them, so that they can be free to understand the human problems of the patient and find a constructive approach to them.

Apart from producing a general therapeutic atmosphere, the main mental-hygiene efforts of the clinic team are focused on trying to identify, and wherever possible predict, situations of emotional crisis. The patient is then helped to deal with her problems in a healthy way.

A frequent problem is presented by women who have to adapt to an unexpected and often inconvenient pregnancy. Few of the young women attending the clinic have consciously planned their pregnancy. In many cases its discovery is followed by a period of emotional upset. Most of these distressed women spontaneously get over the initial upset. By the third to fifth month they accept the inevitable, and develop a positive attitude to the pregnancy. Some feel very guilty because of their initial rejection of the baby and need help in verbal-

izing and reducing their guilt feelings. Unfortunately, their sense of guilt has often been increased by reading mental-hygiene literature on the danger to the child of a rejecting mother. Experience up to the present shows little relation between such initial rejections of the pregnancy and disturbed mother-child relationships.

In some cases the woman's guilt is directed towards her husband, because her pregnancy interferes with his plans for a career. In these instances it has not been unusual to find indications that despite her conscious agreement to postpone childbearing an underlying desire to have a baby was responsible for the "accident." Here too guilt must be uncovered and reduced by the social worker or the psychiatrist, lest it pervert the future relationship to the child.

In another type of case the patient's psychological equipment is not yet mature enough for motherhood. In such instances, the woman is often an overdependent, deprived person. Sometimes her husband consciously or unconsciously initiated the pregnancy against her wishes, and later showed signs of taking over the mother role for which she was unprepared. With such women the reproductive experience often has a maturing effect, as it does on other women, but the health workers have to be constantly on the alert for early signs of disturbed relationships between mother and child.

One such woman began in her seventh month to complain that the baby was becoming a burden, because its kicking was keeping her awake at night. When this subject was discussed with her by the psychiatrist she recalled memories of late childhood, when she was forced to take care of her younger brothers and sisters so that her mother could go out to work. The psychiatrist showed her how she was preparing to transfer her negative feelings toward her burdensome siblings onto her new baby.

In many cases pregnancy seems to stimulate the revival of old emotional conflicts, particularly in regard to unsolved childhood problems of relationships with parents and siblings. This provides an opportunity for the achievement of a new and more stable mental equilibrium. The active emotional support of the clinic workers helps the patient to feel secure enough to come to terms with her conflicting feelings in a more positive way.

Women whose early rejection of pregnancy led them to plan or unsuccessfully to attempt abortion are treated with great care. Previous work has shown how unsuccessful attempts at abortion can easily lead to the building up of pathological anxiety and guilt which produce a specific disorder in the relationship between the mother and her child. The instances encountered so far in the clinic have been dealt with as early as possible. The patient is encouraged by the obstetrician or the caseworker to discuss her act at length, and efforts are made to reduce her excessive feelings of guilt and the consequent fear that she has damaged the fetus and will give birth to a deformed baby.

Mother Love

An interesting finding regarding the early development of the mother-child relationship may here be mentioned. The first manifestations of this link reveal themselves not only in the expectant mother's attitude to conception and pregnancy, but also in her feelings towards the fetus inside her and in her fantasies of the baby-to-be-born. Sometimes very early in pregnancy, but usually after "quickening," women develop love for the fetus which they have come to regard as a little person, and this love may continue unchanged after birth. One such mother said that when she first saw her baby, she knew that it was the person who had been inside her for 9 months. "He was very homely, but his appearance and his behavior were not important—I knew he was mine and I had loved him from the beginning—I didn't need to get to know him." This patient had spent little time during pregnancy daydreaming about what the baby would be like after birth.

Other pregnant women have no positive feelings towards the fetus. They may complain of their discomfort at its movements, and though intellectually they know it is a live being, they cannot conceive of it as a person.

The content and emotional coloring of the fantasies about the expected baby do not appear to run parallel to the feelings about the fetus. In each case, the clinic workers attempt to record the changes in these various attitudes during the course of pregnancy. It is hoped that this data may one day be of predictive value. Meanwhile, the patients are supported in their positive feelings and given a chance to talk freely about any negative attitudes. The resultant release of whatever guilt feelings they may have helps to keep their anxieties within comfortable limits.

Patients are warned in advance of possible changes in their feelings. This is especially important in regard to the emotional time lag after birth, which may last from 3 to 7 days. If during this period the mother experiences no maternal feelings towards

her infant, she is likely to be considerably upset unless she has been told beforehand what to expect. Anxiety at this time is especially inconvenient since it may impede the mutual adaptation of mother and baby to the nursing experience.

In an attempt to shorten this emotional time lag and to smooth her early efforts to relate to the baby as a person, the pregnant woman is encouraged to talk about the concrete aspects of baby care with the nurse and the pediatrician. Special attention is given to such problems as breast feeding, preparation of the layette, and plans for home help. These practical discussions help the mother not only to deal with her emotional reactions, but also to build up a real conception of her future role and to work through some of her anxieties ahead of time.

It is not yet known at which stage of pregnancy such talks should begin. Perhaps, like sex instruction for children, they need to be conducted differently at different stages, because their significance changes. While in most cases women show little interest in problems of baby care during the first trimester, sometimes just talking about babies at this stage helps an ambivalent patient adapt to the reality of pregnancy.

Casework Service

Most of the young parents studied were having economic and social problems more closely connected with the difficulties of starting a family in our culture than with the factor of pregnancy. Pregnancy, however, often aggravates these problems, and is in turn affected by them. Occasionally, the expected baby is in danger of being made the scapegoat for thwarted ambitions or the battleground for marital strife. Casework service to the parents is valuable in averting such an outcome. Young parents are not only stimulated by the clinic's social worker to mobilize their best efforts in dealing constructively with their difficulties, but are discouraged against allowing these problems to become connected emotionally with their relationship to their child.

A difficulty directly attributable to the pregnancy commonly results from the change in sex life. To ensure free communication and understanding by both husband and wife of the issues involved the social worker explores the subject with them in individual and joint sessions. The anxieties, insecurity, and guilt which not infrequently follow when sexual desire and capacity are impaired, are not hard to deal with, but can cause a lot of unnecessary suffering if ignored.

So far, this account has dealt almost entirely with the problem of the expectant mother, as indeed it should, since she is most directly affected by the reproductive process. The expectant father, however, is also important, as is the interaction between the marital partners. Therefore, the clinic makes a point of seeing all husbands at least twice during the pregnancy. Most of the husbands visit the clinic with their wives more often. Certain problems are routinely discussed in joint sessions.

Husbands are encouraged to participate as fully as possible in preparations for the baby, and their own emotional needs are taken into account.

The emotional changes in their wives, brought about by the pregnancy, are particularly and fully discussed with them.

On the basis of this understanding, their help is enlisted to deal with difficulties that may arise. Most husbands are gratified to be given the opportunity to contribute towards a smoother pregnancy. The expectant mother's increased passivity, her mood swings, her emotional irritability, and emotional lability are very important to them. When a man learns that these none too pleasant reactions in his wife are normal manifestations of the internal upheavals of pregnancy, his anxieties are allayed, so that he is able to offer sympathetic help instead of showing annoyance at her "acting up."

The husband who is afraid of "spoiling" his wife during her pregnancy because he correctly diagnoses regressive behavior, can be helped to appreciate his wife's need for increased love and support at this time. He can then realize that during her emotional preparation for motherhood she needs "spoiling" just as she needs an increased supply of vitamins and protein in her diet. This understanding enables him to offer his services with the feeling that he too has a significant role to play.

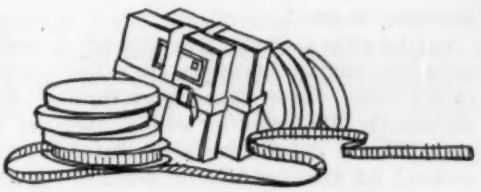
The clinic workers tactfully recognize the possibility that the husband may not quite like the fact that during pregnancy his wife rather than he holds the center of the stage at home. They may also prepare him to cope with feelings of jealously which may appear with the arrival of the baby. A joint discussion with the social worker allows both prospective parents to talk over and reduce their anxieties regarding the change in their relationship with each other which the approaching birth will inevitably entail.

The last few weeks of pregnancy are often the most difficult time for both husband and wife. Be-

cause the expectant mother's physical discomforts are usually increased at this time, she is apt to feel rebellious against the burdens of pregnancy—"always having to wear the same clothes, not being able to run upstairs or take part in ordinary social life, and the drag of this long waiting period." She often becomes more demanding at home and is irritable and disgruntled. A chance to express these negative feelings freely and to be assured of their normality is very helpful to her. If the couple has previously been warned of this phase, the wife will be less anxious and guilty, and her husband will be readier to give her the necessary support.

Superstitious fears about death during delivery or giving birth to a deformed baby may appear at any stage of the pregnancy and are sometimes increased in these last weeks. They are dealt with by being very freely discussed by the obstetrician, the nurse, or the social worker and are never perfunctorily dismissed with blanket reassurance. Instead, the mother is told that such fears are universal and that they may well persist despite her understanding that they are not based in reality, but may be a heritage from former days when many women did die during delivery. True reassurance comes to the mother when she realizes that the specialist recognizes the genuineness of her feelings, but is not made anxious by them. The mental-hygiene efforts of the clinic team have been intensified during the labor and lying-in period, but space does not permit description of this phase of the work. Suffice it to say that in their efforts the team members are ruled by the same principles as during the prenatal period: understanding the patient's individual needs; giving her emotional support; and providing her with calm, nonauthoritarian guidance based on an increasing knowledge of the range of factors leading to healthy adaptation of parents and children.

FILMS ON CHILD LIFE



Films listed here have been review by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

THE FAMILY. 20 minutes, sound, black and white, 1952, purchase.

The unity of a family with modest resources is strained by conflicting individual aspirations, but is strengthened when the parents and the young people get together and admit their mistakes.

Audience: Parent or student groups.

Produced by: Herbert Kerkow Productions for the U. S. Army.

Distributed by: United World Films, Government Films Department, 1445 Park Avenue, New York 29, N. Y.

A TWO-YEAR-OLD GOES TO HOSPITAL. 45 minutes, sound, black and white, 1952, purchase or rent.

A little girl's reactions to an 8-day stay in the hospital show some of the effects of her temporary separation from her parents. Because this film was part of a research project the child was photographed at the same time every day to secure a "daily time sample." The English hospital procedures depicted are in many respects different from those in American hospitals.

Audience: Professional workers; students if time is available for discussion.

Produced by: James Robertson, at the Tavistock Clinic, London, England, in the course of a research project directed by John Bowlby, M. D.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

DR. SPOCK. 27 minutes, sound, black and white, 1953, purchase.

Suggestions to parents on taking care of children of various ages, from early infancy to school age, are presented in an encouraging and reassuring way by Benjamin M. Spock, M. D., of the Western Psychiatric Institute, University of Pittsburgh. The film shows children in typical situations—eating, playing, and sleeping.

Audience: Parents and persons who work with children.

Produced by: March of Time.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 18, N. Y.

SKIPPY AND THE 3 R'S. 29 minutes, color or black and white, 1954, purchase or loan.

The teacher of a first-grade class skillfully sparks the children's interest in learning to read, to write, and to count. They learn because they find a need for learning.

Audience: Parents; citizen groups.

Produced by: National Education Association and affiliated State education associations.

Distributed by: National Education

Association, Division of Press and Radio Relations, 1201 16th Street NW., Washington 6, D. C (purchase); and State education associations (loan).

AND NOW MIGUEL. 62 minutes, sound, black and white, 1953, purchase.

This is a picture of life on a sheep ranch in New Mexico, and of 12-year-old Miguel's longing to grow up and help the older members of his family to care for the sheep. Lambing, the behavior of the ewe and her lamb, the shearing of the sheep—all are depicted with simplicity and integrity as are the boy's touching relations with his older brother, his father, and his grandfather.

Audience: Parents, teachers, other adults, and school-age children.

Produced by: Joseph Krumgold for the U. S. Department of State.

Distributed by: United World Films, Government Film Department, 1445 Park Avenue, New York 29, N. Y.

FOOD AS CHILDREN SEE IT. 18 minutes, sound, black and white, 1952, purchase or loan.

As the title suggests, this film presents the subject of meals from the child's point of view rather than from the adult's. Its lesson for adults: Observe how a child prefers his foods cooked; let him decide how much to eat, giving him a choice of two fruits, for example; and let him serve himself. At the same time, the responsibility of the mother to offer the child foods that contain the essential nutrients is stressed.

Audience: Parents of young children; students of child development or home economics; nurses, child-welfare workers, and others who work with parents.

Produced by: General Mills, Film Department, with the cooperation of the Rochester-Olmstead County Health Unit, Rochester, Minn., under the technical supervision of Dr. Miriam E. Lowenberg.

Distributed by: General Mills, Education Section, Department of Public Service, Minneapolis 1, Minn.

RURAL NURSE. 18 minutes, sound, black and white, 1954, purchase or rent.

In a country town in the Republic of El Salvador, in Central America, a government nurse helps the people with their health problems. Her work is part of a demonstration carried on with the assistance of the United Nations. The film shows the details of the nurse's day—the dust that she plods through, the lack of water in the homes she visits, the warm thanks she receives.

Audience: Citizen groups, teachers from the third or fourth grade on, student nurses and students of related professions.

Produced by: United Nations, Department of Public Information.

Distributed by: Same.

A LONG TIME TO GROW. 35 minutes, sound, black and white, 1951 (Studies of Normal Development), purchase or rent.

First of a series of three films showing school experiences in early childhood, this picture shows little children in nursery school. A psychologist points out the interests and capabilities of the children, and evidences of their growth. The film shows clearly how the teacher is ready to give help when needed and to ease a tense situation without interfering with the children's spontaneous activity.

Audience: Parents, students, nursery-school teachers, and others interested in child development.

Produced by: Child Study Department of Vassar College.

Distributed by: New York University Film Library, 26 Washington Place, New York 3, N. Y.

NURSE MIDWIFERY—EDUCATION AND PRACTICE. 35 minutes, sound, color, 1952, purchase or rent.

A nurse who takes postgraduate training in midwifery becomes a certified nurse midwife and under a doctor's direction cares for women during pregnancy, labor, delivery, and the postpartum period, and also appraises the newborn infant. The picture indicates the various capacities in which certified nurse midwives function—as supervisors of obstetrical departments in hospitals, as instructors at schools of nursing, as consultants in maternity programs, as supervisors of licensed nonprofessional midwives, and as nursing specialists in public-health agencies.

Audience: Professional groups concerned with maternal and child-health programs; students in medical and nursing schools or schools of nurse midwifery; professional personnel in public-health agencies; students in advanced study of pediatric and obstetric nursing; schools of nurse midwifery.

Produced by: Alpha Film Productions for the Maryland State Department of Health.

Distributed by: Alpha Film Productions, 6000 Pimlico Road, P. O. Box 5325, Baltimore 9, Md. Available only as approved by the Maryland State Department of Health.

THE CHILDREN. 10 minutes, sound, black and white, 1952, purchase or rent.

This film shows how the United Nations Children's Fund (UNICEF) works in various countries to feed children and to protect them from disease.

Audience: The general public.

Produced by: United Nations, Films and Information Division, United Nations, N. Y.

Distributed by: Same.

THE COOL HOT ROD. 27 minutes, sound, black and white, 1953, purchase or rent.

A "smart" teen-ager who is going to wake up the slow town he has recently come to narrates the story. Having moved from a place where "hot-rodding" was synonymous with reckless driving in broken-down relics, this boy is surprised to learn that his new town, like many others all over the United States, has a constructive program of hot-rodding. He learns how the town's Hot Rod Club was developed, how the members run their converted stock cars on strictly supervised "drag strips," and how the cars are carefully checked for safety.

Audience: High-school students, teachers, and citizen groups.

Produced by: Sid Davis Productions, 3826 Cochran Avenue, Los Angeles 56, Calif.

Distributed by: Same.

THE MIRACLE OF REPRODUCTION. 15 minutes, sound, black and white, 1953, purchase.

Beginning with flowers, and proceeding through fish and other animal life, this picture moves on to human reproduction. It offers a number of photographs of young creatures to interest children, and uses animated drawings to explain methods of reproduction.

Audience: Young children—below the fourth grade—whose parents approve after having viewed the film.

Produced by: Sid Davis Productions, 3826 Cochran Avenue, Los Angeles 56, Calif.

Distributed by: Same.

THE SECRETARY'S CONFERENCE ON JUVENILE DELINQUENCY

THE ATTACK on the problem of juvenile delinquency must be made on several fronts at once for there is no one remedy or preventive. This was made clear by the 475 persons who gathered together in Washington June 28–30 for the National Conference on Juvenile Delinquency at the invitation of Oveta Culp Hobby, Secretary of Health, Education, and Welfare. Coming from 43 States, the District of Columbia, the Virgin Islands, Puerto Rico, and Guam, they included police officers, judges, teachers, probation officers, clergymen, and representatives of public and voluntary social agencies and of a wide variety of civic, labor, fraternal, and religious organizations. They were asked: to take stock of the methods known to be effective against delinquency; to define the obstacles standing in the way of a successful antidelinquency campaign; and to formulate the steps to overcome them. They were invited, in other words, not just to listen to a "program" but to confer and to produce ideas and suggestions.

It was, therefore, a working conference, with thirteen work groups in all, each provided with a document—sent to the delegates in advance—to serve as resource material. These documents, issued by the Children's Bureau in cooperation with the Special Juvenile Delinquency Project, were the result of 2 years of work with lay and professional groups in assessing the causes of delinquency, what kinds of programs of prevention and treatment are needed, and how these might be achieved. They included among others *Police Services for Juveniles*,[1] *Standards for Specialized Courts Dealing With Children*,[2] *Training Personnel for Work With Juvenile Delinquents*,[3] *and The Effectiveness of Delinquency Prevention Programs*.[4]

Supported by private funds, the Special Juvenile Delinquency Project was established in July 1952 to help the Children's Bureau focus attention of the public on current problems of juvenile delinquency in order to stimulate action toward the improvement of preventive and treatment services. The conference was, in a sense, the culmination of its efforts.

The conferees met together in entirety only twice—at opening and closing sessions, with Dr. Martha M. Eliot, Chief of the Children's Bureau, presiding. At the opening session Secretary Hobby spoke of the tremendous increase of juvenile delinquency in the past 5 years and called for community and individual action based on "a deeper understanding of the enormous intricacy of this malady." Senator Robert C. Hendrickson, chairman of the Senate Subcommittee to Investigate Juvenile Delinquency attributed at least part of the "disparity between what is known about juvenile delinquency and what is done about it" to cleavages in the ranks of professional persons interested in the problem and called for united action among "teachers, judges, psychia-

The drawing at the top of this article is from "The Years Between," by Frances T. Humphreville and Ati Forberg. Scott, Foresman & Co., New York, 1953. Used with the permission of the publisher.

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trists, social workers, representatives of the press, and just plain citizens" toward its solution. Bertram M. Beck, director of the Special Juvenile Delinquency Project, reviewed the past 2 years of joint effort of the Project and the Children's Bureau.

Mr. Beck explained the details of conference planning, and, in accord with these plans, conferees spent the next 2 days in workgroups hammering out recommendations on the particular phase of the problem in which they had special interest. Each workgroup opened with a few remarks by a scheduled speaker to set the stage for the discussion, but from that point on the exchange of ideas flowed freely and informally and ocasionally even heatedly. By the end of the second day a committee of each workgroup had prepared a preliminary report which the group polished into an accepted form at its last meeting the next morning—no mean task in view of the variety of opinions that were presented.

At the closing general session Mr. Beck summarized the workgroup reports for the assembled conferees, and after some remarks of appreciation by Nelson Rockefeller, Undersecretary of Health, Education, and Welfare, the conference adjourned. This may have been more of a beginning than an ending, however, for there were already indications of followup conferences to come in a number of States and local communities, to stimulate the action called for in the workgroup reports.

The recommendations were many and varied but they underscored four basic needs: increased finances to provide the services and personnel involved in the prevention and treatment of delinquency; coordinated community effort to create a wider understanding of the intricacies of the problem; more and better-trained personnel in the public facilities and services that handle delinquent children; more knowledge about delinquency and the effectiveness of various types of programs.

The highlights of each workgroup's specific concerns emerge in the following article, a condensed version of Mr. Beck's summary for the conference.

STEPS TO COMBAT DELINQUENCY

BERTRAM M. BECK, M. A.
Director, Special Juvenile Delinquency Project

IT SEEMS APPROPRIATE to start with the workgroup concerned with counting delinquent children, for statistics are basic to public recognition of delinquency, to planning and evaluating prevention and treatment programs, and for designing research.

In this group present statistics drawn from data collected by the Federal Bureau of Investigation and the Children's Bureau were termed "fractional and noncomparable," and though useful in indicating trends, unable to give a precise picture of the volume or nature of the problem.

The group endorsed the Children's Bureau's efforts to select a national sample of juvenile courts for reporting statistics, and thus reduce the undue statistical influence of a single geographical area, or of highly populated areas. It also urged three technical improvements for future statistical recording: (1) use of "the child" rather than "the case," as the unit of counting, in order to avoid duplication; (2) development of a device to yield information about children who repeat offenses; (3) a sharpening of definitions, particularly those pertaining to unofficial cases.

This group envisaged the Children's Bureau as the nerve center of a national operation to collect comprehensive figures on delinquents from all agencies dealing with them, as well as certain aspects of program, such as cost and personnel. It also urged States to set up composite indices and localities to establish central registries, properly protecting the identity of each child, to provide an unduplicated count of children involved in delinquent acts, and so serve as the basis for informed public action.

This group recommended: that the Children's Bureau statistical staff be strengthened; that the States be urged to adopt legislation authorizing the collec-

—*Hardy for Dept. of H. E. W.*

Some of the 400 persons who registered at the conference. Each had been sent resource material ahead of time and been assigned to a workgroup in which he had expressed interest.

tion of uniform statistics; that the Bureau of the Census take a population count every 5 rather than every 10 years, so that more current child-population data would be available in calculating delinquency rates.

Prevention

While the double focus of the entire conference was on prevention and treatment, one workgroup was charged especially with considering how current knowledge about prevention might be applied. Out of its deliberations came a strong warning against looking for a single cause for delinquency or a single answer to the problem and an emphasis on the importance of interdependence of program, planning, and coordination. It called citizen knowledge and participation imperative to successful preventive efforts and pointed out that the efforts of family, church, and school, and of other social institutions, can aid in combating delinquency, just as their deficiencies or failures can contribute to the problem. While recognizing that fundamental knowledge about delinquency prevention is limited, the group stressed the need for community understanding of the current large body of knowledge based on experience with delinquents and study of normal growth and development.

While world, national, community and family problems are possible sources of personality tensions, their influence can sometimes be offset by helping individuals to understand their nature and achieve a balanced attitude toward them, this group reported. It also expressed a belief that children are not born delinquent, and that their proper guidance and protection is rooted in religious, spiritual, and ethical concepts.

Parents, its members said, must be helped to accept responsibility for discipline and guidance, but they added that measures to punish parents for their children's misdemeanors have not proved successful. This group stressed distinction between constructive discipline and retaliatory punishment—holding that the latter was futile as a means of rehabilitation. This view also emerged from the workgroup on the role of the parents.

The Parents' Role

Changing cultural patterns engrossed a large portion of the attention of the workgroup on parents, particularly in regard to the influence of comic books, television, radio programs, and movies. While the participants agreed that some material provided through the mass-communication media is harmful to child development, they expressed various opinions on the issue of whether the problem could best be attacked by educational methods or by legal censorship.

Noting that parents must be helped to their own fulfillment in order to aid their children, the group commended the growing interest in developing techniques to aid "hard to reach" parents.

Considering the working mother, the group agreed that a mother's employment outside the home may complicate family living but does not necessarily lead to family breakdown. The participants pointed out that work may help some mothers feel more adequate as persons and therefore as mothers. But they also cited Department of Labor studies showing that the majority of women who work do so from economic necessity.

The group delineated several principles for helping parents discharge their responsibilities: (1) citizen participation in planning; (2) efforts to help parents clarify their values; (3) the establishment of specific but flexible goals for children and parents; (4) acceptance and reassurance of parents by professional persons; (5) furthering a sense of parents' personal worth. They deemed a long-term educational emphasis as sound but also saw the need for short-term emergency measures.

Two viewpoints emerged in this group in regard to leadership in parent education. There were those who called for professionally trained leaders, and those who believed that lay leadership under supervision is the only feasible way of getting the job

done. These differences came closer together as the discussion indicated how professional leaders and the less highly trained might mesh their efforts.

This group, too, warned against the search for a panacea, agreeing that no one profession or no single approach to delinquency prevention would be suitable for all communities or for all families within one community; that the parent-education job must involve numerous public and voluntary organizations, sectarian and nonsectarian; and that these must be supplemented by measures to reduce social and environmental pressures on families. Pointing out that gross inadequacies in Aid to Dependent Children programs in many States were forcing mothers to work outside the home, the group adopted a resolution calling attention to the underlying purpose of the ADC program—to preserve family life.

Both the prevention and the parents workgroups stressed the family as the primary source of the child's sense of worth as a person, and family welfare as inextricably tied into community welfare.

The Schools

The workgroup on schools recommended that the school program be broad, flexible, community-focused, and designed to fit the abilities and potentialities of each child and the whole child.

The group suggested that each school develop an inservice training program for teachers and other school personnel as well as a staff-relations organization and that each school system set up a broadly representative school-consultation committee, separate from the board of education, to further mutual understanding between school and community. The group urged that parents be encouraged to visit schools.

The school group also called for curricula geared to individual needs, suggesting special groupings, supervised work-school programs, and, for certain children, residential treatment centers under public-school auspices. It proposed an experimental out-of-doors work camp school for teen-agers, youth-participation programs, and the use of qualified law-enforcement officials in the school curricula to help the students understand law enforcement and their personal responsibilities as citizens.

Urging that the teacher-pupil ratios be reduced to not more than 25 children per teacher, the group recommended long-range planning to anticipate financial needs plus Federal grants-in-aid to the States for specialized personnel. It also called for increased appropriations for the Office of Education of the Department of Health, Education, and Welfare to sponsor workshops, develop pilot projects, further research, strengthen and expand its publishing and information program, and assist teacher-training institutions in developing experimental programs.

Referring to the need for information to identify predictive factors in childhood maladjustments and for exchanging information on programs relating to childhood disorders, the participants recommended continuous accumulative records for each child throughout his school career. Recognizing that the exchange of this information among community agencies involves delicate problems of confidentiality, they suggested that these must be handled differently in various communities, according to the degree of mutual confidence among agencies.

The Police

The workgroup on police services stressed a need for adequate police personnel to handle children who come in conflict with the law and for training police officers to deal with them.

Among the obstacles to proper preventive efforts by the police, the participants noted poor salaries, nonrecognition of the importance of their part in prevention, confusion as to their appropriate responsibilities, and inadequacy of community services for children and youth.

Recreation and casework services under police auspices are not functions of police departments nor compatible with accepted principles of community organization, this group maintained, but it granted that when community resources are inadequate a police department might appropriately call attention to needs and even sponsor an agency to meet them. The group held that the police function does not include casework but includes sufficient social investigation to elicit information basic to an adequate referral or disposition of the case.

The discussion revealed differences in local practices in regard to fingerprinting children picked up by the police, but the group agreed that all fingerprints of juveniles, except those involved in serious crime, should be destroyed along with other recorded material; and that retention be only with the consent of the juvenile court and for a juvenile bureau. The group called for withholding all police and court records of juveniles from the scrutiny of any persons but those actually concerned with the case, except where public interest requires disclosure. It urged

police departments: to study their services to juveniles with an eye to organization and function; to set up carefully considered requirements for juvenile police personnel; and to respect the constitutional rights of the child and his parents at all times. It also requested the Children's Bureau to add a consultant on police services to juveniles to its staff.

Detention

One of the greatest obstacles to effective police work with juveniles, said the police group, is the lack of proper detention facilities. Substantial evidence for this point came out of the workgroup on detention. There it was maintained that 100,000 children aged 7 to 17 years are held in jails and lock-ups each year, awaiting action by the courts, while others are detained in grossly substandard detention facilities; and, that detention would be unnecessary for many of these children if the juvenile courts had adequate probation services and closer coordination with the police, since only children who are a danger to themselves or to the community or who are almost certain to run away need secure custody. The group suggested regional or district detention homes for use by sparsely populated counties and called on the States to help the counties in developing these and upholding good standards of operation.

Among the obstacles to good detention the group cited: confusion as to the responsibility of the State government; failure to recognize need for professional services; insufficient national and State consultation and guidance; insufficient guidance materials; inadequate community services; the perpetuation of vested interests; and political interference. As remedies, the group called for a program of civic education and action. It pointed out, however, that in some instances, especially in regard to regional detention centers, improvement would require changes in State laws.

Juvenile Courts

The workgroup concerned with juvenile-court and probation services gave its major attention to the new Children's Bureau publication, "Standards for Specialized Courts Dealing With Children." Although there was some disagreement among participants over a few details, the publication as a whole was strongly endorsed.

The group enumerated a number of characteristics as essential to effective juvenile-court operation: a properly qualified judge; a staff adequate in size and training; proper detention facilities; protection of records; hearings involving the collaboration of various professions; adequate statistical data; treatment resources to meet the needs of children before the courts.

The group condemned the practice of transferring children from training schools for delinquents to penal institutions for adults, without benefit of judicial process. Calling for the development of more specialized treatment facilities, it suggested that in some instances such resources might be established through interstate action. The participants also held that confidentiality of records should not prevent appropriate information from being given to schools, institutional treatment centers, and social agencies having a legitimate role in working with the individual child. In advocating close cooperative relationships between juvenile courts and the press, the group maintained that the courts had an obligation to protect the privacy of individual offenders by safeguarding them against indiscriminate publicity, but not to put a cloak of secrecy around the total operation of the court.

Institutional Treatment

The workgroup on institutional treatment saw the goal of institutional treatment as a modification of the child's concepts of himself and of his relation to others. The process, said the participants, must be through the establishment of an interpersonal relationship with an understanding adult. Therefore they advocated that the services of social worker,

Each workgroup had four sessions. At the first, a speaker summarized the problems to be dealt with. At the closing session, the group formulated its recommendations. In between, delegates gave problems and solutions a thorough going-over.
—Singer for Dept. of H. E. W.

psychiatrist, and kindred staff be focussed on helping all institution personnel—educational, vocational, religious, and others—to increase their understanding of the youngsters with whom they work and their skills in helping them.

The group held that training schools should not be administered by an agency that has as its primary purpose the administration of programs for adult offenders, but should be related to other services for children. It recommended smaller institutions, with adequate physical plant and personnel, well-planned groupings of children, adequate intake controls, and a relationship between the training schools and the communities and States in which they exist.

Coordination

Nearly every workgroup called attention to the need to coordinate services. The workgroup assigned specifically to the subject defined "coordination" to include efforts to increase effectiveness of services, factfinding, research, joint planning and action, and public information, at various levels of activity. It excluded from the functions of coordination the actual handling of delinquent children or the operation of any direct service.

While advocating that coordinating devices be directed at the total needs of children and youth rather than solely at delinquency, the group recognized that local efforts will necessarily vary in make-up and focus. Nevertheless, it envisaged a model coordinating committee composed of governmental officials, professional staff, and interested lay citizens.

The group called for more public funds for planning and coordination, especially for staff assistance. It warned coordinating bodies against placing goals so high that participants become discouraged. The coordinating process, it pointed out, requires patience and the capacity to let things grow at a rate that permits sound development.

Competition between existing agencies for funds, staff, and status can hinder effective coordination, according to this group, but citizen participation in planning can help to overcome this obstacle.

In considering coordination of services, the group stressed the importance of early discovery of children with behavior problems, diagnosis of their difficulty, and appropriate referral, and recommended the integration and continuity of treatment services, with emphasis on a family-centered program. It advocated case conferences and interagency agreements, followup on specific cases, and the encouragement of outpost services at points where persons in distress appear.

For coordination on the State level, the workgroup advocated interdepartmental committees of official State agencies as well as State commissions or committees on children and youth. While it agreed that advantages are derived from having such commissions appointed by the Governor or established through legislation, it recognized that a number of successful State coordinating and planning bodies have been self-organized.

The group suggested that concern for juvenile delinquency might be lodged in a subcommittee of the State commission on children and youth rather than in a special State coordinating committee on juvenile delinquency. It also suggested that each State place responsibility in an official department or body for providing leadership in the development of research standards and consultation on planning machinery to local groups.

The group also saw a need for coordination and leadership at the national level. It urged the Secretary of Health, Education, and Welfare to form an advisory committee of national agencies, private and public, to be concerned with the provision of technical aid in program operation and planning, dissemination of public information, factfinding and research, and training of personnel.

This group also advocated coordination in neighborhoods and recommended youth participation in the coordinating process.

Training

A number of workgroups—especially those on detention, juvenile courts, police, and prevention—expressed concern about the training of personnel. The workgroup specifically assigned to the problem recognized financial stringency as a major obstacle to more widespread training. While recognizing that support for services could and perhaps should be, in part, financed by the States themselves, it maintained that Federal aid supplementing State or private appropriation is the only hope for real and significant progress in providing what is necessary and especially for any significant development in research and training. The allotment of Federal funds is vitally necessary and consistent with governmental tradition, said the members of this group, since juvenile delinquency is a problem of the people of this Nation.

Accordingly, the group passed a resolution presupposing the establishment of a National Council on

—*Hardy for Dept. of H. E. W.*

The panels of this display on juvenile delinquency reverse automatically, one side showing the extent and cost of the problem, the other suggesting five steps to improvement. The exhibit is available on loan from the Children's Bureau.

Juvenile Delinquency charged with the implementation of a Federal grants-in-aid program in the field of juvenile delinquency and presupposing that the Secretary of Health, Education, and Welfare would provide professional staff in this connection either within an existing governmental structure or a newly created one. The group saw the projected National Council as having subcommittees on service, training, and research, with funds and staff to operate in each of these areas. It recommended that appropriations include $3,000,000 annually solely for the purposes of training. The group also urged State legislatures to make funds available for the development of staff.

The training group agreed that all casework personnel, regardless of place of employment, needs to understand the problem presented by aggressive youth and the structure and function of the official agencies concerned with them. Referring to a common core of knowledge basic to all personnel in the field of juvenile delinquency, the group advocated inservice training programs and the establishment of training centers, attached to schools of social work or other appropriate agencies, to help persons now on the job who have lacked specialized preparation.

State Legislation

The workgroup concerned specifically with State responsibility held that sound principles of administration and organization must be incorporated in statutes and provision made for full utilization of available facilities and services.

The group agreed that any welfare legislation for delinquents must be drafted in the light of all welfare needs and services for all children, but recognized that varying conditions within the States suggest alternative approaches: (1) the concentration into a single package of all legislation and welfare administration for children, including services to delinquents and predelinquents; (2) a separate legislative and administrative package for services to delinquent children and youth.

The participants noted that drafting legislation requires technical skill; that sound legislation can only be evolved with sound knowledge of existing statutes; that furthering legislation calls for knowledge of the rules and methods of legislative procedure and a sense of timing. Persons supporting legislation, they said, must be clear as to the points on which compromise is preferable to failure and those on which it is not.

Legislative efforts require a different approach in each State and in each situation, the group maintained, pointing out that ordinarily a great deal of groundwork must be laid before specific legislation is achieved. Elaborating, it suggested that representative citizens, key organizations, and individual legislators must be made acquainted with the issues involved and the reasons for advocating specific types of legislation, and their views and reactions solicited; but it added that occasionally an unexpected incident serves as the rallying point for citizen understanding and support.

Research

Many workgroups discussed research needs, on the theory that success in tackling delinquency depends on expanding knowledge, especially stressing the need for research aimed at evaluating current efforts.

The workgroup concerned particularly with research began its deliberations by discussing the problem of basic research *versus* applied research, but as discussion proceeded, dropped the "*versus*" and decided that both types of research are needed. The most pragmatically based study may have important implications for basic theory, and *vice versa*, the group declared, but added that since the "practical" or evaluative study more easily attracts support, it may also be oversold. On the other hand, the group maintained that research into the basic determinants of human behavior must be promoted with complete frankness about its inability to produce quick results.

This group pointed out that juvenile delinquency is essentially a legal concept and not an entity that lends itself to scientific study, and that to be effective in regard to it research must be directed to certain

aspects of human behavior patterns associated with it, such as resistance to authority.

The group also defined needed areas of evaluative research. These included studies of family environment to determine what type of family structure is productive of what kind of behavior; studies of impulse control in normal and disturbed children to determine what causes the differential; studies of the influence of community values on the development of behavior. The group suggested a study of the incidence of antisocial behavior to obtain keener data on how people really do behave, how frequent delinquency is, what normal and deviant behavior actually are.

The group found "shocking" the practice of spending large sums to continue programs while making little or no expenditures to find out what they are achieving. Most agencies, it pointed out, find it hard to obtain funds for studies during their early stages when the research is being designed.

This group passed a resolution calling attention to the need for research personnel and the need for more knowledge about delinquency and asking that Federal funds be made available to States, localities, and universities for the stimulation, support, and extension of significant inquiries into the causation, treatment, and prevention of persistent antisocial behavior in children and adults and for the education of competent research personnel.

Civic Action

All through the conference came the call for civic action and support to achieve the kind of programs that can best combat juvenile delinquency.

The juvenile court group suggested several ways for courts to achieved a constant and continuing program of interpretation to the community. The detention group cited the need for citizen effort to develop a merit system and other protection against political interference, and urged the use of the mass media of communications to promote public understanding. The groups concerned with institutions, with parents and with legislation also called for efforts to further public understanding.

The group especially concerned with civic action held that citizens, while relying on experts to help, must see for themselves what the situation is and what needs to be done. Professional persons must alert communities to their needs, the group maintained, and promote continuing leadership by determining where the central core of each community is. It placed the responsibility for action on localities but recognized that they may need State and National help in highlighting needs, stimulating interest, and providing advice and consultation.

The workgroup emphasized the importance of lay and professional groups working together and using the various channels of communication to dramatize social problems. It also recommended that State conferences on curbing delinquency be organized as early as possible to continue the work of the nationwide conference. Urging that this national conference be considered the beginning of a continuing community-action program, the group called for the development of a national action group, similar in representation to the conference. It suggested that the Children's Bureau carry on the program begun by the Juvenile Delinquency Project, and that the Advertising Council be asked to undertake an intensive educational campaign concerning juvenile delinquency.

Finally, the group noted that the increased number of children, the growing mobility of families, and other changing cultural factors demand a bold approach by the country as a whole to assess needs and determine which most appropriately may be met by local and State groups and which are Federal responsibilities calling for Congressional appropriation. We must and will, the group said, have the courage and wisdom to invest in our children to insure their and the Nation's future.

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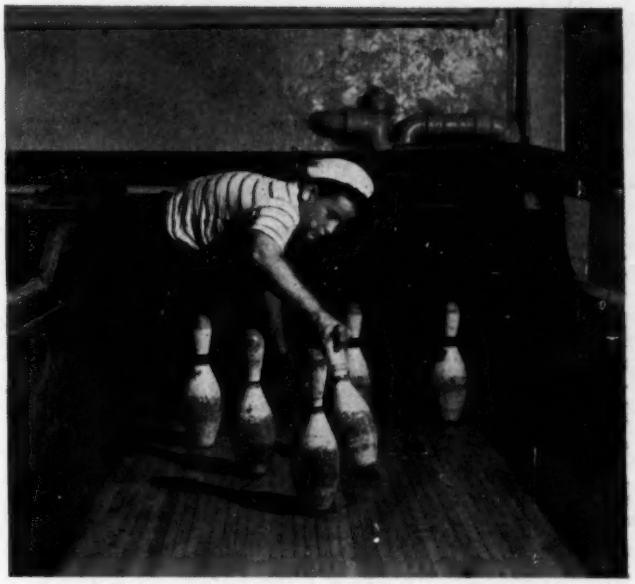
[1] Police services for juveniles. Children's Bureau Pub. 344. Washington, D. C.: Government Printing Office. 1954. 91 pp. 35 cents.

[2] Standards for specialized courts dealing with children. Children's Bureau Pub. 346. Washington, D. C.: Government Printing Office. 1954. 99 pp. 35 cents.

[3] Training personnel for work with juvenile delinquents. Children's Bureau Pub. 348. Washington, D. C.: Government Printing Office. 1954. In press.

[4] The Effectiveness of Delinquency Prevention Programs. Children's Bureau Pub. Washington, D. C.: Government Printing Office. 1954. In press.

A BREAK FOR PINBOYS



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RECENT COORDINATION OF EFFORT on the part of national organizations which have become aware of the dangerous and unhealthy aspects of the pinboy's job promises to reach into the bowling alleys of the Nation to protect children and youth. Led by the Advisory Committee on Young Workers, of the Bureau of Labor Standards, U. S. Department of Labor, the concern of these groups crystallized sufficiently at a conference last February for a program to be ready for the current bowling season. Most significant element, perhaps, is the inclusion of leaders in the bowling industry itself. But its success will be measured by the degree of awareness it arouses in States and local communities among those concerned with children's health and welfare, of conditions under which pinsetters work, of the place of bowling-alley regulation in the overall program of child protection and of the vigilance required if good standards are to to be observed.

By 1940, 45 States had some child-labor regulation of bowling-alley employment. In recognition of the factors that make this type of job unsuitable for young boys, 24 of these States had set a higher minimum age for pinsetters than for most other employment. But labor shortages during the war led to attacks on these standards in many areas. The 5 States that had a minimum age of 18 for pinsetting were pressed into reducing this minimum to 16 or lower. Then bowling alley proprietors found that they could not get enough 16-year-olds to man the alleys, either. The job was so hard, the hours of work so undesirable, and conditions so bad, that boys of legal age for factory employment shunned pinsetting as work "for kids who don't know any better." Attacks were then made on the 16-year minimum age laws and the nightwork prohibitions which in many States would have kept boys under 16 from being used in the alleys during the busy evening.

The results were that after the war, although slight gains had been made in 3 States, child-labor regulations in bowling alleys had generally been greatly weakened. Six States had a *lower* minimum age for pinsetting than for other employment. Eleven States had no minimum age for outside school hours employment of pinsetters, 5 of these having no nightwork prohibition either, thus permitting boys of any age to work all night. One State had reduced its 16-year minimum age to 12. Six States had dropped the 16-year minimum to 14, and night-

—Photo From McCall's Magazine

work restrictions were widely relaxed or ignored. Wartime relaxation of most other labor laws had been temporary and were removed after the war. But it seemed impossible in most States to get back to the child-labor regulations for bowling alleys which they had had, and which were necessary to protect the health and welfare of boys. Eventually the Korean conflict again tightened the labor market and very young boys continued to set pins into the late night hours in most parts of the country.

Complaints and requests for help came in increasing numbers to the U. S. Department of Labor from school officials, health and welfare workers, officials in State departments of labor, and many other organizations and individuals concerned about the wholesome development of boys. Therefore, the Department's Bureau of Labor Standards decided to make a survey of conditions and to get the opinions and suggestions of those close to the problem in a number of communities.

Working Conditions

From this survey emerged a picture of the job of pinsetting and of its effect on the boys. It found that since bowling alleys are busiest in the evening, pinsetting nearly always involves nightwork, usually until 11:30 p. m., often later. School-attendance workers complained that truancy resulted because boys were too tired to get up for school or had suffered injuries on their jobs in the alleys. Teachers told of boys falling asleep in class because they were worn out from the late hours and hard work. One school superintendent told of a 10-year-old boy who set pins from 4 to 10 p. m. 4 nights a week and of four others, all under 14, who worked from 4 p. m. to midnight 7 days a week. The irregularity of attendance that resulted from such employment caused school failures and early dropouts. School health workers reported that the boys were often missing their meals and living on candy bars and cokes bought at the alleys where they worked. School officials in general reported a correlation between poor health, poor attendance, poor scholastic achievement, and work in bowling alleys.

Pinsetting is extremely hard work, too, particularly when the boy serves two alleys. The ball used in tenpins weighs 16 pounds. Each player rolls the ball about 50 times during the course of the three games bowled by each league. Since there are usually five men on each team, the boy must pick up and return the 16-pound ball 500 times during the 2 hours of league play. Stooping to pick up and return the ball, picking up and setting the pins, leaping over the partition to do the same for the competing player in the next alley requires not only great speed but much energy as well. When boys work from 4 p. m. to midnight on this job, they can hardly avoid exhaustion.

Pinboys are also exposed to considerable accident hazard. Typical injuries which are mentioned frequently in the records of State labor departments are broken or mashed fingers, broken noses, concussions, split lips and loss of teeth, lacerations on various parts of the body, leg fractures and bone injuries caused when boys are hit by balls and flying pins. One State reported 135 pinsetters among the workmen's compensation cases closed the preceding year. Seventy of these had some degree of permanent partial impairment and 9 others were compensated for serious and permanent disfigurement. The remaining 56 cases involved temporary disability of over 6 days' duration. One 13-year-old boy in New England was hit on the ankle by a ball. Osteomyelitis resulted which kept the boy in and out of hospitals for years and, although several operations were performed, the boy was permanently disabled. Total compensation paid was $10,798 plus $2,332 for medical expenses.

Many accidents to pinboys are not reported, sometimes because there is no coverage under the State workmen's compensation laws, but often because the employer does not recognize his responsibilities for reporting. Sometimes accidents come to light only when the youngster is absent from school or when the injury is so serious that the parents seek help.

Employment Practices

Other adverse conditions which cause many people to regard pinsetting as a bad job for any boy arise from poor employment practices. Many proprietors do not seem to think of themselves as employers or regard the pinsetter as their employee. Boys come in off the street, are put into the pits to work, and are paid off when the rush is over. Neither the boy nor his parents know when, or how long, or where, or if, he is going to work when he starts out to make the round of the alleys, looking for a chance to pick up some change. In some cases the boys were missing from their homes for several days, sleeping on cots or rags in the alleys, because they worked so late they were afraid to go home. This practice is especially serious where adult "drifters" work and sleep in the alleys along with the boys.

Recordkeeping is neglected in many alleys. Often

the proprietor does not know the boy's full name or his address, or whom to notify if an accident occurs. Many of the boys do not have employment certificates even in States where these are required.

A pinboy gets little training, usually only what he picks up from observation while hanging around the alleys. Supervision is inadequate, because the proprietor, concerned primarily with the bowlers' end of the alley, is apt to pay little attention to the pits except to speed up the boys or to get underage boys out of the way when a labor inspector is rumored to be approaching. School officials say that one of the industry's worst evils is the disregard for law engendered in boys who are taught to lie about their ages or sneak out of the alleys.

The adult companionship to which the pinboy is often exposed on his job is another detrimental feature. Bowling alleys are chronically short of pinsetters, and derelicts or drunks from the cities' "skid rows" know they can pick up quick money by setting pins. Often they bring their liquor into the pits with them. The pastimes behind the scenes while boys wait for bowling to begin may include gambling, cards, and all sorts of horseplay. In this setting some boys conceive and plan antisocial activities which they carry out on their way home. In some communities gangs of pinboys leaving the alleys late at night have been involved in looting cars and other acts of vandalism.

Even in States with laws prohibiting employment of boys under 16 late at night widespread violations were reported. State enforcement officials reported that their staffs were too small to get around to all the alleys during the night hours. They said that judges often seemed to be more sympathetic to the manpower needs of the proprietors than to the plight of the boys. When open and determined defiance of the law exists, enforcement is almost impossible.

When the Bureau of Labor Standards presented its report,[1] *The Boy Behind the Pins*, to its Advisory Committee on Young Workers, the committee suggested that representatives from the Bureau and the committee approach leaders of the bowling industry and bowling leagues to dicuss the findings and to enlist their understanding and cooperation in support of law observance and improved employment practices. The committee also recommended that the Bureau call together representatives of national organizations concerned with youth in order to create an awareness of the situation and to stimulate moves for improvement in the many communities represented in their membership.

Discussions with representatives of proprietors' associations and bowling congresses showed that these organizations realize that improved conditions would raise the status of bowling and help bowling-alley proprietors by improving their community relations, reducing turnover among pinsetters, and making it easier to recruit an adequate supply of pinsetters. It became clear that proprietors could do much to make the job suitable for and acceptable to older boys. The proprietors' representatives agreed to explore the possibility of drawing up a code of good employment practices which its representatives felt their membership would accept.

Plans for Improvement

Representatives of national organizations concerned with youth and of the proprietors' associations and bowling leagues met in February at the invitation of the U. S. Department of Labor to develop a program for improving conditions for pinboys. The National Child Labor Committee contributed information from a survey of pinboys which it had conducted,[2] the League to Promote School Attendance reported on its poll of school-attendance officers' opinion,[3] and representatives of State departments of labor and others told about conditions in their areas and measures that had been, or might be, tried.

At this meeting representatives of the Bowling Proprietors Association of America reported on proprietors' difficulties in securing an adequate labor supply. They expressed a desire to remedy bad conditions where they exist, but maintained that these are not typical of all bowling alleys. However, they pointed out that their efforts would be handicapped by the newness of their association and the fact that not all proprietors belonged to it. As proof of their good intentions they presented their suggested code, *My Pinsetters and I, a Guide to Good Practice*,[4] which if followed would do much to make the job better for properly selected boys. In this code the proprietors undertake to: observe their State and local laws regarding pinsetter employment; provide healthy and safe working conditions; supervise the conduct of boys in their employ and protect them from undesirable influences; cooperate with parents and school authorities in regard to working hours and employment arrangements for boys.

Since the conference the national organizations of proprietors and bowlers have circulated the code to over 6,000 bowling-alley proprietors urging that

they post it and live up to its responsibilities. They are also getting it to the bowlers through their bowling leagues and bowling journals.

The citizen organizations represented at the conference are supporting the program of the proprietors and bowling organizations by publicizing the code in their journals and in program letters to local affiliates urging that they bowl in alleys where the code is posted and observed. They recognize, however, that there is still much to be done by citizen groups. Some States still have no legal minimum age for employment in bowling alleys, some have a substandard minimum. There are sometimes pressures to break down the 16-year minimum age in States that have achieved that standard. At the conference these organizations agreed to work for good laws and law enforcement and to prevent breakdowns in child-labor laws in States where there is now a legal 16-year minimum age.

Community Action

Pinsetting as practiced in many bowling alleys today involves both the health and welfare of children and youth, and is therefore a proper concern for all those charged with the well-being of children. Community workers who come in contact with boys whose problems stem in part from their work in bowling alleys can bring this fact to the attention of their professional and lay associates. They can work with other groups in carrying out some of the suggestions for community action set forth in *The Boy Behind the Pins* and *Up Your Alley*. With first hand understanding of the problem they can help bowlers see the importance of refusing to take their recreation at the expense of the boys in the pits, and can help parents and young boys understand why pinsetting is not a good job for young people.

The national campaign to improve conditions for the half million pinsetters employed during the course of a year, launched so auspiciously last February, cannot succeed unless interested groups in every community support it. Local improvement in conditions will come through the action of individuals and community-wide cooperation. Many communities and organizations need to join in Statewide moves to get and keep good legal standards.

Such action can be effective. Last spring two bills to break down the child-labor law in Massachusetts and one in Louisiana were defeated because enough informed and concerned citizens made their influence felt. In one Iowa community women bowlers who became aware of the problem through their national organization refused to bowl in an alley where underage pinsetters were employed. This is the kind of language every proprietor understands. When individual proprietors in each community see that the public really cares what happens to the boys who work in their establishments, improvements will be made.

Who takes the lead in stimulating community concern will vary from place to place. It may be a council of social agencies in one community, an attendance officer or health official in another, or a youth council in a third. Everyone can work together to see that action on behalf of pinboys results from all this information and concern. The bowling season is on. If action has not started in your community, pick up the ball and get it rolling.

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[1] The Boy Behind the Pins. U. S. Department of Labor, Bureau of Labor Standards, Washington. Bull. 170. 1953. 48 pp. For sale at 25 cents by Superintendent of Documents, Government Printing Office. Single copies available without charge from the Bureau of Labor Standards, Washington 25, D. C.

[2] Alway, Lazelle: Up your alley. National Child Labor Committee, 419 4th Avenue, New York 18, N. Y. Pub. 410. 1953. 31 pp. Single copies free. Write for quantity rates.

[3] The other end of the alley; a report presented at the Conference on Improving Conditions for Pinsetters, by John A. Cummings, President, National League to Promote School Attendance. 1954. 4 pp. Single copies available without charge from the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

[4] My pinsetters and I; a guide to good practice. Recommended by the Bowling Proprietors Association of America. 1954. 1 p. Single copies available without charge from the Bureau of Labor Standards, U. S. Department of Labor, Washington 25, D. C.

To me the worst vandals are not children but the adults who wreck the character of children and destroy the lives of children by their attitudes. Children are the most beautiful things I know of.—Lawson G. Lowrey, M. D., former director, Institute of Child Guidance, New York.

What the United Nations and UN affiliated agencies are accomplishing in their . . .

INTERNATIONAL ACTION FOR CHILDREN

JULIA HENDERSON, Ph. D.
Director, Division of Social Welfare Department of Social Affairs, United Nations

UNDER ITS CHARTER, the United Nations and its affiliated agencies have a mandate to seek "higher standards of living" and "conditions of economic and social progress and development" for *all* of the 2½ billions of people living on this planet. Even if we limited our activities entirely to the underdeveloped areas of Asia, the Middle East, Africa, and Latin America, we would be dealing with about 1¾ billion people, 80 percent of whom live in villages and rural areas.

Even in the advanced countries rural areas are the last to share in public health and welfare services. The United Nations preliminary report on the *World Social Situation*[1] concluded that the peasants of the underdeveloped areas have been the forgotten men of the 20th century and have benefited less from its changes than any other group. Our best estimates indicate that half of the people in the world are still living at levels which deny them a reasonable freedom from preventable disease; a diet adequate to physical well-being; a dwelling that meets basic human needs; the education necessary for improvement and development; and conditions of work that are technically efficient, economically rewarding, and socially satisfactory.

Against the vastness of these needs are the facts that the United Nations and most of its specialized agencies are less than 10 years old and have total resources of less than $25 million per year for assisting governments in the health, nutrition, education, labor, and welfare fields, if we exclude the emergency-relief programs in Korea and the Near East.

Should we then despair and consider that the language of the Charter is simply "pie in the sky"? While we are not the incurable optimists who believe that progress is inevitable, most of the representatives and officials of the United Nations still believe that our goals *are* attainable if we harness man's vast spiritual and physical resources to our common objectives. The United Nations, after all, is not working *against* the stream of history but is a reflection of the fact that fatalistic resignation to poverty and disease is giving way to the demand for a better life. Every government is now wrestling according to its abilities with the problem of its population's standard of living. The UN's job is to foster mutual aid, to find the common denominators in successful national experience, to stimulate both governmental and nongovernmental agencies to the utmost outlay of creative energy to raise the general welfare.

International Social Program

What is it that the United Nations adds to the efforts of national governments, of voluntary societies, of self-help efforts of the people themselves in raising their standard of living and achieving social progress and development?

To begin with, the UN Department of Social Affairs has added to the systematic knowledge of social problems and to the analyses of the background data necessary to economic and social planning. Through its statistical and demographic offices it has worked extremely hard and with considerable success in improving the quality and scope of the midcentury censuses. For the first time,

Based on a paper given at the 1954 forum of the National Conference of Social Work.

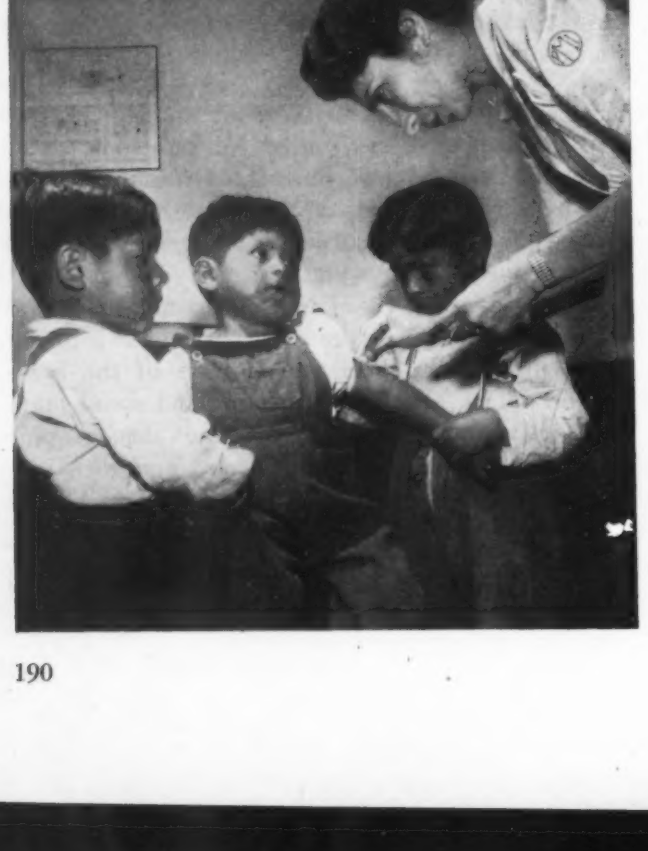
many underdeveloped countries have at their disposal an intelligible array of facts concerning the characteristics of their own population—they know how many children they have, how many aged, something more of their birth and death rates, occupational structure, income levels, housing conditions, educational levels.

The importance of these data for social planning cannot be overestimated. The Population Division has analyzed population trends and pointed out the relationship of the facts and the projections to economic and social development.[2] The Division of Social Welfare has analyzed many national social programs on a comparative basis—for example, measures to strengthen family life[3]—as a background for social policies to be recommended to governments. The Division of Social Welfare has prepared the comprehensive reports, the *World Economic Situation* and the *World Social Situation*, to serve as guideposts for both national and international action.

I cannot enumerate here, of course, the growing wealth of technical studies in every field of social endeavor which the international agencies have prepared at the request of their member States; suffice it to say that anyone in the health or welfare fields would be forced to be highly selective in choosing the documentation most helpful to his community or agency in improving health, education, labor, or welfare services.

In Peru, where in certain areas inoculation against typhoid is necessary, two "big" boys help their little brother prepare for his shot. The mass protective project is part of a public health program aided by the World Health Organization.

—WHO Photo



Combined Efforts

Not a few of these studies represent the combined efforts of the United Nations, one or more of the specialized agencies and the nongovernmental organizations. For example, the Division of Social Welfare undertook a study of the adoption of children in 13 countries around the world with the active cooperation of the International Union for Child Welfare,[4] the Secretariat undertaking the legislative aspects of the study and the Union making the major contribution on adoption practices with the help of national committees. As a companion study, WHO, with the collaboration of UN, called an expert committee composed of psychiatrists, psychologists, pediatricians, and social workers on the mental-health aspects of adoption.[5]

The necessity for governmental cooperation in furnishing data for these technical studies highlights at the same time a major strength and a major weakness in United Nations work. On the positive side, governments find that they must analyze themselves in order to answer the questionnaires of international agencies. While officials grumble about the work involved, they confess privately that it forces them to think about their social problems, to coordinate the efforts of many ministries and even at times to find new methods of National, Provincial, and local cooperation. On the negative side, the UN's very dependence on governmental sources of information sometimes keeps it from uncovering the real facts or at least restricts its freedom to publish facts to which it has no official access.

In addition to this social research, which has great importance as the tool of policy formulation, the United Nations and the specialized agencies in the social field have undertaken considerable practical fieldwork. This falls into two broad categories: direct assistance to special groups such as refugees and displaced persons; and technical assistance to governments in the social field.

There is the work in Korea. In the shadow of an uncertain future for that devastated land the United Nations Korean Reconstruction Agency is carrying on health and feeding programs, agricultural reconstruction, education, rehabilitation of the handicapped, care for homeless children, and perhaps most

—United Nations

Pupils at one of the rural schools in Sitio del Nino, El Salvador which has adopted curriculum proposed by UNESCO.

encouraging of all, community development projects. In close cooperation with the United Nations Civil Assistance Command UNKRA must bind up the wounds of this land.

There is also the frustrating history of aid to 800 thousand Palestinian refugees who are the victims of the birth of a new nation in the Middle East. They are still UN wards in their crumbling mud shacks and tents, with their meager wheat and milk ration, awaiting the political settlement which will allow some or all of them to return to their homeland or find new homes in the Arab States. A few thousands are now working on economic deveopment projects supported by the United Nations Relief and Works Agency and the host governments, but the great majority must spend their days in unproductive activity and in bitter contemplation of their fate. The youngsters are in classes established by the United Nations Education, Science, and Cultural Organization, and health and welfare services are provided for the whole of the refugee population.

The bridge between the supply and emergency relief programs on the one hand and technical assistance activities of UN and the specialized agencies is United Nations Children's Fund, known as UNICEF. This Fund was put on a continuing basis by the General Assembly in 1953 and the words "emergency" and "international" stricken from its title. This has not detracted one iota from the sense of urgency felt by the members of UNICEF's Executive Board, for as the delegate from Israel said: "The needs of children are always an emergency."

The primary emphasis of the Fund continues to be on mass health programs. With the cooperation of the World Health Organization and the participating governments, which more than match every cent of UNICEF aid, 50 million children have been tested for TB and 22 million vaccinated with BCG antituberculosis serum. Mass-feeding programs have served another 11½ million mothers and children. Since 1950, however, the nature of the UNICEF programs has shifted to long-range activities. Health and nutrition programs, milk conservation in the form of pasteurization and drying plants, and partial support in supplies and equipment for 5,300 maternal and child health and wefare centers are included in the impressive score of UNICEF activities to the middle of 1953.[6]

The story of the joint action of UNICEF, WHO, the UN Department of Social Affairs, and the Food and Agriculture Organization was told to the 18th session of the Economic and Social Council last July. Examples were the successful collaboration of the four agencies in providing a new soybean-milk production unit in Indonesia and protein-rich fish flour for children in Chile. In both cases, FAO and WHO cooperated in finding local foods which would meet the protein needs of children and in

A survey team of a government nutrition program in Thailand, aided by FAO experts, examines a rural family's food supply.

—FAO Photo

carrying out acceptability tests before UNICEF helped the governments by providing engineers and equipment for producing these foods. Regional social welfare advisers have participated in nutrition conferences both in Indonesia and Latin America to ensure that feeding programs of UNICEF and FAO are carried out in a manner that will bring lasting rather than short-term benefits to mothers and children. Another example of joint action is represented by the Maternal and Child Welfare Center in Bangkok, Thailand, one of the many established with UNICEF and WHO assistance. A UN social-welfare worker included in the team has successfully organized a local advisory committee for the Center to provide it with roots which may be expected to preserve it after international assistance is withdrawn.

Technical Assistance

The Technical Working Group on Long-Range Activities for Children, which is composed of specialists from the UN Division of Social Welfare, UNICEF, WHO, FAO, UNESCO, and ILO, meets regularly to work out joint policies and programs at the Secretariat level so that proposals to the governing bodies of all the agencies may be in harmony. One important joint action decided upon at its 1951 meeting was the program to assist governments in assessing the needs of children in their country and examining all their services for meeting those needs. Such assistance has been given to Burma, El Salvador, and Syria in the past 12 months by the joint efforts of the agencies concerned. Self-examination of this kind by any government inevitably reveals the gaps in services, the need for better coordination, and it offers a sound basis for international help.

The technical-assistance activities of the United Nations in the social field are hardly less dramatic and their practical impact in relation to the dollars invested is most encouraging. An increasing amount of our staff time, supplemented by nearly 750 experts yearly and nearly 750 fellowships to applicants from the underdeveloped areas [7] goes into these long-range activities to assist governments in initiating or improving health and social services.

For example, take the work of WHO in the control of malaria. During the year 1953, WHO assisted 21 countries in malaria control, in many cases in cooperation with UNICEF. The director-general of WHO and the executive director of UNICEF have both reported that 1953 may well prove to have been the turning point in the history of malaria control. Many of the countries of South East Asia and the Middle East are attacking malaria as a national health problem. WHO has offered training of many kinds to meet the increasing demands for assistance in strengthening national malaria-control organizations, and each team has provided systematic practical training in malaria projects. It has also given assistance to malaria institutes and centers for training in insect control.

Health authorities and, to a growing extent, economic ministries have long recognized that the malaria scourge was a major obstacle to economic development, costing the nations, in tropical areas in particular, millions of man-months of labor every year. The people themselves in many countries have demonstrated their enthusiasm for the kind of help which they are receiving from the international or-

ANOPHELES ON THE RUN

Only a few years back the malaria-carrying anopheles mosquito was designated as world health enemy Number One by the World Health Assembly. Now it looks as though this indivious insect's days may be numbered, as an increasing number of governments level concerted attacks against it. In these efforts they are aided and abetted not only by the United Nations specialized agencies as described in the accompanying article but also by the Foreign Operations Administration of the United States.

Of the nearly 400 United States technicians working in 38 nations overseas in FOA technical-cooperation programs in the health field, many are engaged in malaria-control programs in the Near East, South Asia, Africa, Far East, and South America. FOA, for example, supplied equipment and training for teams that DDT-sprayed 80,000 houses per month in North Vietnam, Indochina, a total of 220,000 houses in the Philippines, and 13,000 villages in Iran, and contributed to amazingly successful antimalaria programs in Venezuela and Brazil. In India, where malaria causes 1,000,000 deaths a year, FOA has furnished $5 million worth of DDT equipment which will be used to spray 125 million houses.

ganizations. In Afghanistan, for example, the people of a remote section in the North petitioned their Government to maintain the WHO malaria-control team in their area.

Malaria control is only one aspect, of course, of the important work being done in the health field. There are also effective efforts in regard to maternal and child welfare, such as the centers already mentioned. In addition, recognizing that spectacular gains in the health field must be established on the bulwark of strong public-health organizations, WHO has concentrated a sizable portion of its resources on the strengthening of national health services. It has worked not only in the national capitals, but also in outlying areas where teams of experts have demonstrated the effectiveness of coordinated public-health, nutrition, education, and welfare services.

Aid to Education

This kind of effort in the health field is closely paralleled in the fundamental education program of UNESCO. This agency has recently given an increasing amount of attention to primary schooling for children and fundamental education for adults and children who have not had the advantage of formal schooling. Thus it attempts to reach the illiterate with the simple facts about their environment, their health and welfare, and the means of increasing their agricultural production. This type of instruction is in many countries combined with special literacy campaigns.

Two regional fundamental-education centers established by UNESCO in Patzcuarro, Mexico, and Sirs-el-Laiyana, Egypt, draw teams of young men and women from the 20 Latin American countries and the 6 Arab States for training as fundamental education teachers. On their return home these trainees establish similar centers in their own countries for training teachers and community leaders. Thus UNESCO is contributing to the total effort in community development being made by UN and the specialized agencies.

In the labor field, the International Labour Organization has stepped up its work in vocational training as a direct contribution to economic development. At the same time it has pursued its long-term efforts to see that any improvements in productivity go hand in hand with advances in social policy leading to better conditions for the workers and better food, clothing, housing, and other necessities. To achieve these ends, the ILO has worked closely with governments on legislation concerning hours of work, holidays, safety, and other labor standards. At the same time the agency has fostered the cooperative movement, particularly in countries of South East Asia, where the cooperatives are making an important contribution to the development of their economy. The ILO also makes advice available in the fields of vocational guidance, employment-services organization and the protection of women and young workers, thus helping the underdeveloped countries to avoid much of the stress and personal and social injustice which accompanied the industrial revolution in the West.

The FAO is also making a contribution in the social field, particularly through its nutrition and home-economics programs. It has established special institutes for the study of local foods and local diets in a few areas. One of the most successful is the Nutrition Institute in Turrialba, Costa Rica. This work is particularly important if the efforts of UNICEF are to have a long-range effect, for, since the countries cannot indefinitely feed their hungry children on imported milk, new local sources of proteins, fats, and minerals must be found.

One of the more important projects of the FAO has been its cooperative effort with WHO in an attempt to stamp out kwashiorkor, a disease of protein deficiency. As a result of powdered milk furnished by UNICEF, the effects of this widespread disease among African children have already been mitigated. The FAO, however, is going at the roots of this problem by encouraging the production and use of native protein foods.

FAO is also giving considerable attention to the home-economics side of agricultural extension systems upon which it is advising many of the countries in underdeveloped areas. UN's findings in regard to family and child-welfare services indicate that the management of the household and preparation of food can make almost as important a difference in the standard of living in many countries as any actual increase in food production.

Social Welfare

Space limitations prevent me from giving more than the highlights of the activities of the UN Division of Social Welfare.

The broadest opportunity for assisting a government in an advisory capacity came in a request from Burma for UN help in preparing a new and comprehensive program of social services. Burma, which had previously accepted assistance from the United

—United Nations

Two students at the Demonstration Center for the Rehabilitation of the Blind in Cairo, Egypt. Established with the cooperation of the United Nations Technical Assistance Administration, the center trains Braille printers and teachers of the blind, prints textbooks and teaches crafts to blind people.

States in the preparation of its economic development plans, was eager to have a parallel plan for the distribution of the accruing economic benefits to the most needy parts of its population. Accordingly, UN sent a team to Burma, headed by its regional social-welfare adviser, and including experts in labor welfare, family and child welfare, community organization, primary education, and health services. The team's report has already been accepted by the Government of Burma and UN advisers are now helping to carry out its recommendations.

Similarly, UN has seized the opportunity of assisting two other Governments, Syria and El Salvador, in a survey of their services for children. A series of concrete recommendations to help those governments fill the gaps in their programs and improve the organization and training of their child-welfare staffs have resulted.

UN is stepping up its activities in training both professional and "community" social-service workers. In the past 7 years it has sent missions to 18 countries to establish or improve professional schools of social work. In recent years the Division of Social Welfare has been particularly conscious of the need to extend the interest of the professional schools to the training of auxiliary and community workers. In light of the pleas made in the Social Commission by representatives of underdeveloped countries, the Division has urged that the professional social workers themselves undertake the responsibility for training aids who must carry out all the work in the villages, emphasizing that such workers be considered as supplements to professional social workers and not as substitutes for them. In a cycle of three meetings on the best methods for training auxiliary and community workers held in Gandi Gram in India, Beirut in Lebanon, and Bogota in Colombia, UN experts have searched out the persons who are actually running village institutes and training courses for community workers and have explored with them the reasons for success or failures. The Division is now discussing the results of these meetings with the specialized agencies in the hope of undertaking some joint demonstration training courses in 1955.

The international program for rehabilitation of the handicapped has captured the imagination of many social and health leaders interested in the work of the United Nations. Again, this is a field requiring the combination of the social welfare interests of the UN with the health, education, and labor interests of its affiliated agencies. Un has worked with these agencies as a team to establish demonstration centers in Yugoslavia and Egypt and will soon establish similar centers in Brazil and in India. The nongovernmental organizations have cooperated splendidly in these efforts. Currently UN is exploring the possibilities of establishing a new demonstration center in Turkey with the help of the World Veterans Federation, because of UN's moral responsibility for the handicapped Turkish veterans of the Korean war.

The Division of Social Welfare is also giving major attention to the prevention and treatment of juvenile delinquency. Following discussions at meetings of experts in several countries the Division has granted a number of fellowships and scholarships to social workers and administrators dealing with these problems in the underdeveloped countries. In a few cases advisers have been sent to the countries. The countries most interested in this problem in our Councils and Commissions are the countries now undergoing a rapid economic development—a reflection of the fact that the rate of juvenile delinquency seems to increase with the rate of urbanization and industrialization.

An important phase of UN's work in the social field is its program for the extension of low-cost housing. UN has recently collaborated with the Government of India in a large-scale exhibit of stabilized earth construction. More than 1,000 houses and a complete community center were built as a model,

each house constructed for less than $1,200. Since thousands of people per day visited the exhibit the project promises to have a real impact throughout South East Asia. The exhibit terminated with a seminar which made a number of specific recommendations to governments in that area concerning public housing programs, use of local building materials, and the use of self-help techniques for rebuilding the villages. The relationship of this program to the community-development program is becoming more clear each year as we send out experts in this field.

There is scarcely an important social program on which UN is working which does not require the joint action of the health, labor, education, and welfare agencies on an international as well as on a national level. This is particularly demonstrated in the community development program, in the training programs, and in our efforts to strengthen our administration of social services in the underdeveloped areas. The Economic and Social Council has directed that special attention and concentration be given these areas for the next few years.

The Results

What has been the impact of this development of international social policies, of this volume of technical assistance, and the limited amount of direct aid in special areas?

In the health field, the results are impressive. Malaria has been greatly reduced. It is estimated that the incidence of tuberculosis among children in the areas in which WHO and UNICEF activities have been concentrated will decrease by 80 percent as the result of the injection of 36,000,000 children with BCG.

In education, UNESCO activities harnessed with the governments of the underdeveloped areas have increased notably the number of children in school, lessened discrimination against girls, and turned the emphasis in primary education on fitting children to live in their environment. The problems of teacher training, basic training materials, and school buildings are still tremendous obstacles to the advances which countries are psychologically ready to accept.

Against poverty, our progress is least impressive, The age-old problems of wornout land, low productivity of labor, poor organization of the labor market, poor distribution of industrial plant and "know-how" are not problems to be solved with the wave of a wand or a magic drug. Here international efforts most need to be combined with the bilateral programs of economic aid and technical assistance and national moves to increase industrial and agricultural productivity and international trade. UN and its affiliated agencies are making a contribution on the social side of these efforts by helping countries to anticipate the problems of dislocated families, urbanization, delinquency, and special needs of children, and to help them organize their welfare services to avoid many of the mistakes made by the Western world in the period of its industrial revolution.

The UN is doing its utmost to improve the quality and geographic spread of its program, to coordinate the efforts of the United Nations family of organizations, and to interpret the program in a way which will command public support and the full cooperation of nongovernmental organizations.

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[1] UN Publications Sales No. 1952. IV. II. Document E/CN.5/267/Rev. 1.

[2] Determinants and Consequences of Population Trends (Document ST/SOA/Ser. A/17—Sales No. 1953. XIII.3).

[3] Economic Measures in Favor of the Family (Document ST/SOA/8—Sales No.: 1952.IV.6).

[4] UN SOA "Study on Adoption of Children" (ST/SOA/17).

[5] Technical Report Series (WHO) No. 70.

[6] UNICEF—The Compendium—Vol. IV—1953–54.

[7] 6th Report of the Technical Assistance Board to the Technical Assistance Committee. (Will be available for distribution to the public in June 1954.)

Our crisis is a crisis in values, in the things men live by and for. . . . It can be resolved for the better only through a change in the quality of human relations beginning in the family and school and reaching out to the ends of the world.—Robert J. Havighurst, Ph. D., University of Chicago.

PROJECTS AND PROGRESS

Prematurity and Congenital Malformations

Findings about congenital malformations, resulting from research studies in Europe and the United States, recently received the careful attention of scientists from both sides of the Atlantic. The occasion was the second conference on Prematurity, Congenital Malformations and Birth Injuries, sponsored by the Association for the Aid of Crippled Children and held in New York, June 15–16. Nearly 50 scientists from the United States, England, Scotland, Wales, Ireland, Norway, Sweden, and Finland attended. Their attention was focused on: sociological-clinical problems, especially the effects of external environment on the fetus; the placental barrier; and the fetus in relation to energy stores, internal milieus, and respiration.

In order to further a free flow and exchange of ideas, the conference had been patterned along the lines of informal discussion, with few set papers prepared or delivered. A rich store of knowledge emerged from which it is possible in this space to record only a few highlights. The full proceedings will, however, be published in a forthcoming book now being prepared from tape and stenotyped recordings.

Dr. Theodore Ingalls reviewed some of the findings of his research into congenital malformations and immaturity sponsored by the Association for the Aid of Crippled Children at the Harvard School of Public Health. He believes that these studies show: (1) that there is no single cause of a given malformation, but any one of several causes may result in the same malformation; (2) that most anomalies develop *in utero* as a result of multiple interacting factors; (3) that some of these (largely genetic) cannot be controlled to any great extent, but that others such as infections and nutritional imbalances may be susceptible to control by concerted research, and by clinical, medical, and public-health measures; (4) that the causes of deformities and of intrauterine deaths are closely related and hence efforts calculated to affect either may influence the other; (5) that considerable evidence exists to indicate that the type of defect is determined more by the host (mother) than by the injurious agent; (6) that according to animal experimentation, anoxia (lack of oxygen) at various stages of pregnancy, particularly in the first trimester, is one of these injurious agents.

Dr. James Walker, of the University of Aberdeen, Scotland, reported on studies made over a 15-year period by Dr. Dugald Baird at Maternity Hospital, where 95 percent of all first pregnancies in the city of Aberdeen receive care. Dr. Baird's findings hold significance for social workers and public-health personnel as well as pediatricians and obstetricians everywhere for they reveal that the babies of women in Aberdeen's highest economic class showed the lowest stillbirth rate and the lowest rate of infant death during the first week of life. The infant death rate in this group was 24 per 100,000 as compared with 44.6 per 100,000 for women in the lower economic groups.

The same study showed that deaths due to fetal deformity were 1.4 per 1,000 in the upper economic bracket and 10.9 per 1,000 in the lower; while deaths due to prematurity were 5.6 per 1,000 in the upper and 13.9 in the lower brackets.

Dr. Walker listed the five social groups which were used as a basis for the study: professional and other well-to-do people; intermediate; skilled workers; semi-skilled; unskilled. While many changes have rendered the economic differences between these classes much less clear since World War II, Dr. Walker believes they still represent different standards of living which are reflected in standards of health and physique.

Drs. Walker and Baird have produced evidence to substantiate a view long held by many observers in this and other countries: that the efficiency of reproduction and the vitality of children produced by any group of women is largely determined by their state of health and physique and that this in turn depends to a large extent on the social conditions in which they were brought up from birth.

Their studies reveal further that tall women (5 ft. 4 in. or more) have a lower infant mortality loss than short women (5 ft. 1 in. or under). This is apparently true because, in Aberdeen at least, taller women come from higher economic levels and have better pelvic bone development. Tall women in Aberdeen produced an infant mortality rate of 29.4 per 1,000 compared with 47.1 for short women.

While the extremes of malnutrition are rare in Aberdeen, the highest incidence of prematurity, and of infant deaths due to unexplained prematurity and deformity, clearly occurs in the lowest economic groups. In these groups the women have as high a standard of medical care as those in other groups. Dr. Walker pointed out that once economic class is taken into account, diet, paid employment during pregnancy, and housing seem to have no influence whatsoever in the results.

Discussing the role of the obstetrician in preventing stillbirths, Dr. Walker said: "It seemed clear that skilled antenatal care, good care during labor and pediatric care of an equally high standard can help to save many infants who would otherwise die or suffer permanent damage . . . However . . . in deaths or disability primarily due to deformity or unexplained prematurity, the powers of the pediatrician are very limited, chiefly because the pattern of behavior is to a certain extent defined in extremely early pregnancy."

Dr. Samuel Kirkwood, formerly of Harvard and now Commissioner of Health for Massachusetts, provided additional evidence to back Dr. Walker's theories in a report on a nutritional study of 216 women, made by Bertha Burke of the Harvard School of Public Health. Mrs. Burke's findings showed that all types of stillbirths and major congenital deformities, and all but one of the causes of deaths within the first week of life, were found among babies of underfed mothers.

The conference also examined evidence indicating the part played by various environmental factors in the production of anomalies in infants, in the hope of finding some way of lowering still further the newborn death rate. This rate in most Western countries has dropped from between 30 to 40 per 1,000 live births in 1928, to 20 per 1,000.

Professor John Lind, of the Department of Physiology, Norrtulls Hospital, Stockholm, Sweden, presented an unusual motion picture depicting the first breath of a newborn infant. In reporting on how this was made, Professor Lind said that infants who had not yet

started to breathe were placed upon a fluoroscope screen. Radiation of a very low intensity was turned on and the image picked up by television was intensified. The face of the television screen was photographed at a speed of 40 frames a second on movie film.

The film showed first the tiny rib cage of an infant just after birth with the shadow of the enlarged heart in the center of the screen. With the first breath air filled the lungs and at that moment the heart shadow shrank as its content of blood was drawn into the now inflated lungs. Then the lungs emptied and the heart increased in size as normal flow of blood started from the lungs back into the heart. Regular breathing and heartbeat then followed.

Dr. Samuel R. M. Reynolds of the Carnegie Institution of Washington, chairman of the conference, suggested that the method used in making these motion pictures might be of great value to researchers in their search for ways to prevent the crippling afflictions that arise from accidents at or near the time of birth.

In another report Dr. Ross A. McFarland of the Harvard School of Public Health told of studies indicating that the characteristics of an individual's breathing may be as unique as his handwriting. These produced some evidence that breathing patterns established in infancy may persist throughout life. Irregularities in breathing may reflect emotional abnormalities, Dr. McFarland suggested, reporting that there is some correlation between an unstable personality and a tendency to rapid, shallow breathing. Other members of the conference compared this finding with those of similar studies conducted on wartime pilots in which all steady and competent pilots were found to be deep, slow breathers.

The discussions of these and other significant studies on the causes of prematurity and congenital malformations will be reported in detail in the conference proceedings now being prepared by an editorial committee headed by Dr. Reynolds.

Leonard Mayo
Director, Association for the Aid of Crippled Children, New York

Cost Analysis

The method of cost analysis developed for family agencies by John G. Hill, research director of the Philadelphia Health and Welfare Council, was recently applied to two privately financed children's agencies in Pennsylvania in studies prepared by graduate students of social work at Bryn Mawr College. The studies required adaptation of Mr. Hill's proposed cost centers (described in THE CHILD, November 1953) to the functions of the specific children's agencies under scrutiny. For instance, at the Delaware County Children's Aid Society, one of the agencies studied, these were classified as: Counselling Service, Pre-Adoption Service, Temporary Short Time Care Service, Long Time Care Service, Special Care Service, Student Training, and Participation in Community Planning. Collateral cost centers included Foster Home Finding and Licensing, Staff Education and Development, Public Relations, General Administration, and Research.

Time studies of each staff member against these classifications revealed costs, incurred to maintain agency standards, that were not identified in the agency's budget appropriations. Similar findings emerged in the study of the Lehigh County Children's Aid Society, the other agency involved.

Physical Therapists

Beginning this fall California's Board of Medical Examiners will examine physical therapists who are seeking certificates of registration.

California, which established a register for physical therapists a year ago, is the most recent State to do so. Nineteen States and the Territory of Hawaii now have such registers, with laws prohibiting use of the title, "registered physical therapist," by any person not listed with them. In six of these States—Arizona, Maryland, New Mexico, New York, Pennsylvania, and Wisconsin—practice of physical therapy by unregistered persons is forbidden by law.

Adoption

Three years of effort "by lay citizens for the benefit of lay citizens" are represented in the Final Report of the Citizens Committee on Adoption of Children in California. Completed in 1953, the work was financed by the Rosenberg and the Columbia Foundations. Its goal was "to improve and extend adoptions and related services through the development of public opinion in relation to what constitutes the proper protection and care of children."

The State committee and 12 county committees grew out of a conference on adoption problems called in 1949 by the Los Angeles Welfare Council and the welfare plannnig bodies of San Francisco, San Diego, and Oakland—all concerned over a growing public resentment of adoption-agency practices which had accompanied a greatly increased demand for babies to adopt. Part of this resentment came from a widespread belief that institutions and foster homes were full of adoptable children.

At the request and with the financial assistance of the State committee the Los Angeles County Committee gathered information on more than 3,000 children in boarding homes and institutions in the county who had been placed by social agencies—but did not include the 14,000 other children in boarding homes and institutions in the county who had been placed by their own parents.

The Los Angeles County Committee reported than 12 to 18 percent of children studied were "in need of adoption planning" though only 2.5 percent were at the time legally free to be adopted. It also reported that inadequate adoption services in the past had resulted in a backlog of children in foster care. However, it put the major blame for the large number of children away from their own homes on an insufficiency in community services to help families keep their homes intact or to rehabilitate them so that children in foster care might be returned home.

The State committee investigated the State adoption laws and found them good, except for inadequacy in provisions to help unmarried mothers. It recommends a change in the statutes to remedy this defect and offers specific suggestions for improving adoption services to protect the children, natural parents, and adoptive parents, and for provision of better welfare services generally in the community. A complete adoption service, the committee found, is dependent on the availability of related welfare services.

New protections for persons involved in adoptions have applied in Virginia since July 1, when 1954 amendments to the State adoption laws became effective. These reduce from 2 years to 6 months the period in which the validity

of an adoption can be challenged. They also provide that an umarried mother's consent to adoption is not valid unless given at least 10 days after the birth of the child, thus minimizing the chances of her giving up her child under duress while she is still suffering the effects of delivery.

Needy Children

California's State Department of Social Welfare is taking steps to improve its services for children in boarding homes and institutions who are receiving assistance under the State program of Aid to Needy Children, which includes the program known in other States as Aid to Dependent Children. These children represent fewer than 10 percent of all children on the ANC rolls, but the Department points out that their problems have not received the same attention as have those of the children living with their mothers or other relatives, partly because they represent such a small proportion of the total caseload. Most of the procedures followed in carrying out the ANC program were planned for the larger group, acording to the Department, and therefore it is now developing patterns of administration to meet more adequately the needs of the children away from home.

Failure to meet these needs, the Department finds, is associated with a number of factors, among them: differences in interpreting the extent of county responsibility for serving children; insufficient efforts to keep children with their own families; failure to include parents in planning; inadequate planning for children going into foster care; failure to prepare older children for the time when they will be "on their own."

The Department plans the following steps to remedy these and other deficiencies:

"(a) Guide material will be developed to assist the local agencies in applying the regulations '. . . to keep children in their own homes wherever possible and to provide the best substitute for their own homes for those children who must be given foster care.' One project will be the preparation of a handbook to include a set of working principles to help county staff in dealing with the children, parents, and foster parents, as well as methods to help agencies in working with each other.

"(b) A standard to assure adequate care for children in foster homes will be developed.

"(c) Guides specifically aimed at helping the older children prepare for eventual self-maintenance will be developed.

"(d) Analysis will be made of the 'patterns of administration' to determine which appear to be the most workable and efficient in meeting the problems of this group of children.

"(e) Assistance will be given to counties in those areas of administration of the program which can be improved."

Most of the improvements planned can be carried out under existing statutes, the Department says, although some will depend on changes in the law.

Canadian Social Workers

In Canada, as in the United States, schools of social work have been able to turn out trained social workers in sufficient quantities to fill only a small portion of the positions in public and private social agencies. The disparity between staff needs and the availability of professionally trained persons is made clear in a report recently published by the Canadian Department of National Health and Welfare.

Based on a survey of social work positions in 1949–51, similar to the 1950 study made in this country by the United States Department of Labor, Bureau of Labor Statistics, the report shows the proportion of professionally trained persons to be only 30 percent of all personnel in social-work positions in agencies and only 5 percent of such positions in institutions. The 250 graduates of Canada's schools of social work entering employment each year are not sufficient for the replacements necessary to keep this proportion relatively static.

The survey covered 4,909 positions in most of the voluntary and public agencies and institutions in Canada.

Cerebral Palsy

Since lack of sufficient oxygen at birth may damage an infant's brain and thus cause cerebral palsy or even death, United Cerebral Palsy is financing an effort to develop a test to show when the oxygen level sinks to the danger point. This is one of 32 research projects being carried on at various universities and other institutions through UCP grants.

Another project aims to discover whether incompatibility of blood groups in parents can lead to cerebral palsy in their child.

A clue to a third possible cause of cerebral palsy—virus infection of the mother during pregnancy—is being sought in another study.

Two educational-research projects are also included, the first in UCP's 5-year history. One is a study of the language process of preschool cerebral-palsied children; the other, a comparative study of attitudes of cerebral-palsied children toward school.

Mental Health

New York State's Department of Mental Hygiene has established a new division, the Community Mental Health Service. This division will coordinate a new long-range program, provided for through 1954 legislation, with existing community mental-health activities. The new plan provides for creation of local mental-health boards and establishment of local mental-health services with State aid. These services may include psychiatric clinics, psychiatric facilities in general hospitals, rehabilitation of recuperating mental patients, and consultant and educational services to schools, courts, and health and welfare agencies.

Family Life Education

A 10-year program for expanding and intensifying its educational services has been begun by the American Social Hygiene Association with the help of a grant by the Nancy Reynolds Bagley Foundation. Some of the measures to be taken by the association under this program with regard to education for personal and family living are: To produce and distribute materials for parents, religious leaders, educators, and other youth leaders; to cooperate with other organizations similarly concerned; to sponsor research; and to organize regional projects, each aimed at stimulating three or four States to work together in focusing on the need for adequate preparation of teachers on problems of personal and family living.

Mentally Retarded

With a State appropriation of $50,000 the New York State Mental Health Commission is beginning a pilot study to determine the extent to which severely mentally retarded children can be

educated and trained. The study is being conducted in 12 classes for such children. Five of these classes are in 2 schools under the jurisdiction of the State Department of Mental Hygiene; the other 7 are in city public-school systems.

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The National Association for Retarded Children, an organization of parents with local affiliates in more than 40 States, has recently issued a pamphlet suggesting a program for training the mentally retarded child. Each suggestion has resulted from parents' questions and each has been successfully tried, say the authors, Naomi H. Chamberlain and Dorothy H. Moss. ("The Three R's for the Retarded; repetition, relaxation, and routine." The Association, 129 East 52d Street, New York 22, N. Y. 50 cents.)

Parent Education

About half the parents queried in a recent study of prekindergarten attendance approved of parent education as part of the nursery's program, and even more would like to have had opportunities for parent conferences, parent meetings, and parent observation of the children in the group.

The study, directed by Dr. Catherine Landreth, University of California, and jointly sponsored by the Rosenberg Foundation and the California Committee for the Study of Education, showed that only 14 percent of the 8,000 California first-graders involved had attended nurseries or nursery schools, though nearly half the parents would have liked their children to have the experience.

Children and TV

Interviews with more than 600 families in a small Eastern city indicate that the majority of parents approve of the television programs now being offered children, though many families have some specific objections.

In a study made under the auspices of the National Council of Churches of Christ in the U. S. A. and Yale Divinity School, interviewers collected various social data from a 5-percent random sample of the population of New Haven, Conn., and its suburbs, and found 650 families with minor children, and television sets. These families were questioned about their children's television viewing and the parents' attitude toward the programs that were available.

Nearly half the parents gave unqualified approval to the programs; about a fourth approved, but wanted changes; and the remaining fourth disapproved totally.

Parents who offered suggestions wanted such changes as more programs suited to preschool children; less violence; more educational and religious program; better scheduling of favorite programs to avoid conflict with suppertime.

The average time spent regularly by children 4 through 15 years of age in watching programs was reported by the parents as 13 hours a week. Nearly half of this time was said to be devoted to children's variety programs, somewhat more than a third to Westerns, and less than one-tenth to adult programs.

The report notes the fact that the children undoubtedly watch more adult shows than the small fraction reported by parents. Parents "were reluctant to report such viewing, especially in the evening. . . . The children themselves, however, not only reported viewing adult evening shows but could report their contents accurately."

Juvenile Delinquency

North Carolina's Board of Public Welfare reports that, in contrast to the average picture for the Nation, juvenile delinquency in that State is not increasing.

As evidence of this, the Board points to the fact that in two decades no increase has taken place in the number of delinquency hearings before juvenile courts in relation to population of juvenile-court age (11–15 in North Carolina). In the 5-year period ended June 30, 1934, the State had 6.7 juvenile-delinquency cases per 1,000 persons 11–15 years of age in the population. In the most recent 5-year period for which data are available (1948–52) the figure was slightly lower, 6.2. Thus, although some variations took place in individual years, the incidence of juvenile delinquency in the State has remained substantially the same since the thirties.

The Board also reports that serious offenses charged to juveniles are fewer than they were 15 and 20 years ago, that fewer children are held in jail, that the number of children in training schools is declining. Juvenile delinquency is negligible among children in families receiving Aid to Dependent Children grants, according to North Carolina records.

The Board suggests that these facts may be partly accounted for by the expansion and improvement of North Carolina's child-welfare services.

Here and There

Pennsylvania citizens concerned with the problems of the State's 60,000 dependent and neglected children have recently united in a nonpartisan movement called the Roll Call for Children, with a three-point program: (1) to acquaint the public with facts concerning the problems of child dependency and neglect in the State; (2) to encourage expansion of all services—voluntary and public, sectarian and nonsectarian, local and statewide—to meet the urgent and immediate needs of neglected children; (3) to work toward the adoption of necessary changes in State law to facilitate expansion of services and acceptance of proper standards of child care.

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Controlled fluoridation of drinking water for the purpose of reducing dental caries in children is now in operation in 1,000 communities in the United States and its possessions, with a total population of 18 million.

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Births in the first 6 months of 1954 are estimated by the National Office of Vital Statistics as 1,940,000—registered and unregistered. This is 45,000 more than the births during the same period in 1953. Much of this increase, according to NOVS, can probably be attributed to a continuing rise in the number of third and fourth children. Because of falling marriage rates since 1951 an increase in first births is not expected.

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The National Electrical Manufacturers Association and the National Safety Council have undertaken a joint educational compaign to prevent children from becoming trapped in abandoned refrigerators. Among the materials thus far produced is a fact-finding sheet about the hazards of discarded iceboxes and refrigerators and a small poster to warn children against playing in them.

IN THE JOURNALS

"Overstuffed babies"?

In 22 lively pages the QUARTERLY REVIEW OF PEDIATRICS (May 1954) gives the results of its nationwide survey of "Trends in the Early Feeding of Supplementary Food to Infants," and the comments thereon of a number of widely-respected pediatricians. The emphasis is very much on the "early." Dr. H. L. Barnett thinks that the present earlier introduction of solid foods is apparently related to "the questionable principle" that if a food is nutritionally good, the more of it an infant can retain "without gross signs of toxicity" the better.

Dr. Harry H. Gordon fears that some mothers may, in trying to follow their doctors' suggestions, end up in 6 months with "overstuffed obese babies" who can't possibly go on gaining so fast. Dr. Charles D. May considers that it is up to those who recommend early solid food to "demonstrate real advantages." "The too early addition of added carbohydrate (cereal)," remarks Dr. B. M. Kagan, "may cut down on the volume of milk taken, with its essential contribution of calcium." Dr. Lee Forest Hill suggests that "there is no advantage to introducing solid foods . . . before 3 months of age at the earliest," and that there may be disadvantages.

Dr. Milton J. E. Senn appraises the findings of the survey, which he says, "points up two ominous trends"—the insistence of mothers on giving their babies additional food, regardless of readiness for it, which grows out of an urgent desire to speed up the development of their children; the acquiescence of many physicians to this.

The ways of suburbanites

In "The Separation of Home and Work," in SOCIAL FORCES (May 1954), Leo F. Schnore of the University of Michigan presents the findings of research on the effects of suburban life on living habits, including such factors as ride sharing, the costs of family purchases in outlying areas, the effects of part-time food raising by factory workers on their work-shift preferences. The article does not directly discuss the effects on children and family life, but such overtones are suggested by some of the facts presented—such as the extra hours suburban fathers spend away from home.

The doctors learn, too

When parents of children who have nephrosis or diabetes get together in discussion groups at New York Hospital-Cornell Medical Center they help each other, in addition to getting information and reassurance from the pediatricians who meet with them.

Doctors Barbara Korsch, Lewis Fraad, and Henry L. Barnett, in the JOURNAL OF PEDIATRICS for June 1954, tell frankly of the "individual resentment and diffuse, ill-defined hostility against the medical profession" that spill over when they first have "Pediatric Discussions with Parent Groups." But they find that the anxiety, so natural in these parents of ailing children, is better relieved by group discussions in which similarly burdened parents take part than through the reassurance given individually. Parents can accept, for example, the fact that their children's disturbing resistance to insulin injections is temporary when a parent who has been through the mill tells them so. The article points to the hazards of this group method as well as the benefits to staff and parents.

Airborne fluorides

"Effects of airborne fluorides on children living on Sauvie Island" is the intriguing title of a study reported in the JOURNAL OF THE AMERICAN DENTAL ASSOCIATION for July 1954, by B. S. Savara, Harold Judd Noyes, and Theodore Suher. Were the fluorides, presumably coming from aluminum reduction plants at Vancouver, being assimilated by children through inhalation or through food and water to a harmful or beneficial degree?

The findings: "The daily intake of fluorides was so low that it did not cause mottling of the teeth nor alter the incidence of dental caries." No evidence was found that the children had "consumed excessive fluorides," although "the presence of fluorides in the atmosphere is alleged to have caused damage to the cattle and vegetation."

"Advice isn't the word"

The 16-year-old boy who said this was trying to express what it had meant to him to have some backing in making a new beginning. He decided that what had helped was that he felt he had been "a part of something." Mazie F. Rappaport devotes 25 of the rather small pages of the annual JOURNAL OF SOCIAL WORK PROCESS for 1954 to a discussion of "The Possibility of Help for the Child Returning from a State Training School." The specific efforts she describes are those of the After-Care Supervision Program which the State of Maryland provides for boys and girls leaving training schools.

Family life for crippled children

It is not surprising that Vermont's plan of family living for crippled children receiving care at its Rutland rehabilitation center should be as individual as the scenery and characters in that State. In "Affection by Proxy" Dorothy Smithson and Emily B. Sheldon describe in THE CRIPPLED CHILD for June 1954 how Vermonters thriftily avoided putting money into institution residence and provided children who must leave their own communities for treatment something no granite-faced building could have furnished—the warmth and intimacy of life in a family setting. In 5 years 59 crippled children have been placed in 28 foster homes. An encouraging outcome is that new foster parents often materialize as a result of having seen what some neighbor was able to do for a child.

Group learning

Cooperative exploration and discovery is the basis for a course in the department of psychiatry at the University of Pennsylvania School of Medicine, in which students have the "opportunity to see in operation various phenomena and processes which are important between people." In the July 1954 issue of MEDICAL EDUCATION Kenneth E. Appel and Margaret M. Heyman display "The Psychiatric Social Worker in Group Process Teaching," and show glimpses of what happens to students, sometimes slow to accept the method, and of how the instructors' personalities aid or hinder the worker's aims.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order.

THE NURSE'S ROLE IN THE MENTAL HEALTH PROGRAM. Mary Corcoran, R. N., Esther Garrison, R. N., and Pearl Shalit, R. N. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. 16 pp. 15 cents.

After listing some basic mental-health concepts, this booklet suggests how a nurse can make a more conscious and more effective contribution to the field of mental health. It tells how she can provide emotional support to her patient; how she can help build mental-health resources. Source materials—books, articles, and audiovisual aids—are listed.

GUIDE TO GOOD PRACTICES IN YOUTH DAY-HAUL PROGRAMS SUCCESSFULLY USED IN AGRICULTURE TODAY. U. S. Department of Labor, Bureau of Labor Standards. 1954. 12 pp. Processed. Single copies available without charge from the Bureau of Labor Standards, Department of Labor, Washington 25, D. C.

In a youth "day-haul" program, as defined in this bulletin, groups of young people from cities and towns are picked up daily during their summer vacation from school and taken in trucks or school buses to the fields to harvest crops, as a means of meeting farm-labor needs.

The bulletin recommends standards for such a program with regard to the age and physical fitness of youth selected; written consent of the parents; safe transportation; hours of work; wages; health, safety, and sanitary facilities; and supervision.

In preparing the bulletin the Bureau of Labor Standards received the advice of the Farm Placement Service of the Bureau of Employment Security, U. S. Department of Labor; the Children's Bureau, the Office of Education, and the Public Health Service, U. S. Department of Health, Education, and Welfare; the Federal Extension Service, U. S. Department of Agriculture; and the State and Local Officials' National Highway Safety Committee.

HOMEMAKER SERVICE; a way of helping the long-term patient. Conference on Care of the Long-Term Patient, March 18–20, 1954, Chicago, Ill. Report of the Study Group on Homemaker Service. U. S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 23 pp. April 1954. Processed. Single copies available without charge from the Children's Bureau.

Information on 50 agencies giving homemaker services, obtained through a questionnaire and other sources, is summarized in this report by a study group composed of a physician, a public-health nurse, a medical social worker, 3 social workers with degrees in home economics, 2 citizens active in public-health work, an executive of a local committee on the chronically ill, and a consultant on homemaker service on the staff of the Children's Bureau.

HOME ACCIDENT PREVENTION; a guide for health workers. Federal Security Agency, (now the Department of Health, Education, and Welfare), Public Health Service, Division of Sanitation, of the Bureau of State Services. PHS Pub. 261. 1953. 75 pp. Single copies available free from the Public Health Service.

The Public Health Service has published this outline in response to requests for material on prevention of home accidents, to be used in preparing persons planning to enter public-health work—physicians, nurses, sanitary engineers, health educators, and others. A section on accidents to children is included.

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